DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QTC1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00955

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245233**
2.STATE VENDOR OR MEDICAID NO.
(L2) **633543800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT ANNE EXTENDED HEALTHCARE**
(L4) **1347 WEST BROADWAY**
(L5) **WINONA, MN** (L6) **55987**

4. TYPE OF ACTION: 7 (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/21/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, Health Program Rep Senior 09/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/25/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245233

September 29, 2015

Ms. Jodi Barton, Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, Minnesota 55987

Dear Ms. Barton:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 15, 2015 the above facility is certified for:

109 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all109 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 29, 2015

Ms. Jodi Barton, Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, Minnesota 55987

RE: Project Number S5233025

Dear Ms. Barton:

On August 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 6, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 5, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 6, 2015, effective September 15, 2015 and therefore remedies outlined in our letter to you dated August 25, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245233	A. Building B. Wing	9/21/2015

Name of Facility	Street Address, City, State, Zip Code
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/15/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/15/2015**	ID Prefix **F0327** Reg. # **483.25(i)** LSC	Correction Completed **09/15/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/15/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/15/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/15/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** KS/kfd	**Date:** 09/29/2015	**Signature of Surveyor:** 03048	**Date:** 09/21/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/6/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245233	A. Building B. Wing **01 - MAIN BUILDING 01**	9/5/2015

Name of Facility	Street Address, City, State, Zip Code
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/18/2015**	ID Prefix	Correction Completed **08/18/2015**	ID Prefix	Correction Completed **08/18/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0029		LSC K0062	
ID Prefix	Correction Completed **09/04/2015**	ID Prefix	Correction Completed **09/04/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0064		LSC K0076		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/kfd	09/29/2015	35482	09/05/2015
Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/18/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QTC1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00955

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245233**
2.STATE VENDOR OR MEDICAID NO.
(L2) **633543800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT ANNE EXTENDED HEALTHCARE**
(L4) **1347 WEST BROADWAY**
(L5) **WINONA, MN** (L6) **55987**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/06/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, Health Program Rep Senior 09/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/25/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 25, 2015

Ms. Jodi Barton, Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, Minnesota 55987

RE: Project Number S5233025

Dear Ms. Barton:

On August 6, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 15, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 6, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 6, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Gary Schroeder
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (507) 254-3024
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a dignified dining experience for 8 of 14 residents (R59, R16, R102, R19, R84, R120, R92, R34) observed in three dining rooms on the second and fifth floors. Findings include: R59 was observed on 8/3/15, at 5:05 p.m. as she pulled her food tray towards her body causing the tray with food to tip and liquids being spilled on her lap. One nursing assistant (NA)-H was present in the dining area, who was assisting	F 241	F241 SS = E Facility has system to ensure policies and procedures to promote care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Facility policy regarding Dignity was reviewed and found to be appropriate. Facility nursing staff will receive education related to the expectation of maintaining	9/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/03/2015

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	245233	A. BUILDING _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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F 241	Continued From page 1 another resident at the time. Although NA-H did not observed R59 spilling the liquids, NA-H assisted her in putting the tray on table. NA-H moved back and forth between two tables, assisting two different residents who were dependent in eating at the two different tables. At 5:20 p.m. R59 once again pulled her food tray toward her body. NA-H was able to immediately intervene to prevent spilling from re-occurring. During the mean, NA-H generally stood next to R59 as she assisted the resident to eat. At 5:27 p.m. NA-H moved a resident who was in the process of eating her meal to another table. NA-H then moved R59 to the table where the other resident was seated who was being assisted to eat. During dining observations were conducted on the fifth floor on 8/3/15, starting at 5:24 p.m. and the following morning at breakfast, the following was observed: R16 at dinner on 9/3/15, at 5:24 p.m. was seated at a round table holding attempting to scoop food using an adaptive fork, however, the she repeatedly lifted an empty fork to her mouth. She also attempted to stab macaroni, but the noodle fell off the fork before it reached her mouth. R16 picked up the noodle from her lap and put it in her mouth, and then licked her fingers. No staff were present. At 5:34 p.m. NA-A stood next to R16 and asked, "How's it going?" as she handed her a straw. R16 tried to use the straw, but it continually slipped away and no assistance was provided to the resident to drink. NA-A then stood between R16 and another resident, and gave R16 two bites of pasta. The following day breakfast was observed in the	F 241	or enhancing resident's dignity and respect with the Dining Process. Facility policy was developed for Dignified Dining Experience. Nursing staff will be educated on new policy. Care plans were reviewed for R68, R34, R92, R119, R120, R84, R16, R19, R112, R110 (5th Floor) and were accurate or updated. Residents are assisted with meals from a seated position and staff do not leave the area once the meal is placed in front of a resident unless there is an emergency. Care plans were reviewed for R59, R87, R46, R69, R93, R40, R80, R89 (2nd Floor) Residents are assisted with meals from a seated position and staff do not leave the area once the meal is placed in front of a resident unless there is an emergency. ST and OT order for eval and treatment was obtained for R16 to evaluate the amount of assistance that is needed for dining as well as if her adaptive equipment is still appropriate. ST and OT order for evaluation and treatment was obtained for R59 to evaluate the amount of assistance that is needed for dining as well as if she needs covered cups at meal times to assist with preventing spills. Audits of resident meal and dining experience are being conducted on a	

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F 241	Continued From page 2 fifth floor short west dining room at 9:05 a.m. Six residents (R92, R119, R102, R84, R112, and R110) were in the dining room. One resident was feeding herself and another slept. No staff were present in the room. R92 was brought a tray by NA-F, who sat beside the resident to offer assistance. At 9:51 a.m. R16 was seated in the dining area with her head hanging down, eyes closed with her adaptive fork sticking straight up in her hand. Food on a tray was in front of her on the table and no staff were present. A couple minutes later NA-C walked by in the hall glanced in the dining area where the residents were seated with their breakfast trays, and then kept on walking by. NA-G then walking by peered in the dining area then kept on walking by. No other staff were in the dining area. Five minutes later LPN-E pulled up a chair next to R16 and spoke to the resident. R16 lifted her head and opened her eyes, and attempted to drink a meal supplement drink from the straw handed to her by LPN-E, but the straw kept slipping away from R16. LPN-E stated to R16, "Oh my goodness you have had nothing to drink yet. You usually are drinking." R16 LPN-E then assisted the resident to eat a bite of her waffle and stated, "Oh these bites are so big--I don't know how you can eat." R16 had not eaten any of her bacon. LPN-E asked the resident if she was going to eat her bacon, handed her the supplement to drink, and then left the dining room with no other staff present. At 10:16 a.m. R16 was again sitting with her head down and eyes closed with her tray in front of her when NA-F came into the dining room and washed off the table in front of the resident. NA-F then sat down and assisted R16 to take a sip of water and to drink the supplement. Minutes later NA-F	F 241	weekly basis to monitor and evaluate effectiveness of plan. Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/15/15	

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removed R16's tray of food and left her with the supplement. NA-F then told NA-C, "Normally we have to leave a staff in the dining room because of the risk of resident choking."

R16's care plan dated 6/22/15, indicated inadequate intake as evidenced by extremely low body mass index related to poor intake and difficulty self-feeding. The resident was to use adaptive equipment, and receive set up, and assistance and encouragement at all meals.

R102 was brought to the dining room at 5:31 p.m. sat briefly, and then got up and walked out of the dining room. Staff returned R102 to the dining room and pulled up a small table in front of the resident and placed a tray of food on the table. NA-A redirected R102 back to eat. NA-A was the only staff in the dining room at that time with the residents. NA-A then redirected R102 back into the dining room and handed R102 her fork to eat. At 5:44 p.m. R102 stood up left the room and NA-A left the dining room to redirect R102 back to her chair to finish her meal.

R102's care plan dated 2/2/15, indicated self-feeding difficulty related to dementia and short attention span with the need for constant cues and reminders at meals, set up, encouragement, a calm and quiet atmosphere at mealtime, reminders to swallow, and to refocus attention on feeding self. In addition, R102 had a restorative level III feeding program dated 4/9/13, that directed staff to provide verbal cues and touch cheek to remind resident to swallow and not pocket food (leave food in mouth un-swallowed) and to decrease distractions.

R19 was served her dinner on 8/3/15, however,

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F 241	Continued From page 4	F 241		

she just stared at her food and did not attempt to eat. No staff were in the dining room to offer her assistance. At 5:34 NA-A asked R19 if she was going to eat and she shook her head up and down affirmatively. NA-A stood between R19 and another resident as she asked if she had tried her potato, but did not offer assistance to take a bite. Her juice was put within her reach and she was told it was there by NA-A. R19 took one sip and was encouraged to eat her untouched sandwich. At 5:55 p.m. NA-A offered R19 her spoon to eat her potatoes. then left to go straighten up the area by the food carts.

The following morning when R19 was brought into the dining area and given her breakfast tray, she hurriedly gulped down an entire glass of orange juice. LPN-E approached R19 and asked, "Are you hungry today?" as R19 kept scooping up her waffles into her mouth. LPN-E gave R19 her medications and a glass of juice which she again drank in one drink. NA-F stood over R19 as she peeled and an orange and cued the resident to eat. She stirred the resident's cereal and told her, "You still have your cereal here." NA-F then walked away and began clearing trays and straightening up the food carts. NA-F then walked by and gave R19 a bite of cereal, and then sat to assist the resident to finish her cereal while saying, "You are pretty hungry this morning." R19 shook her head up and down in the affirmative to which NA-F responded, "You must have slept through supper last night."

R19's care plan dated 5/5/15, indicated R19's need for both therapeutic and altered texture diet related to having no teeth and dementia. The resident utilized a scoop plate and required assistance and encouragement for all meals.

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F 241	Continued From page 5 R84 was seated at a table with food and was not eating during on 8/3/15, at 5:44 p.m. NA-A was in the room when R84 stood up. NA-A asked her if she was finished eating or did she want more to eat. R84 said she did want more to eat, but then just stood by the table, and then left the food on her tray and the dining room. R84's care plan dated 7/8/15, indicated inadequate and variable intake related to dementia, a lack of focus at mealtime and increased calorie usage with movement as evidenced by intakes less than 50%. The goal was for R84 to continue to feed self 50% of meals with cues and encouragement. R120 was seated at a table with food and was also not eating on 8/3/15, at 5:44. R120 covered up the uneaten food on her tray with a towel, and left the room. NA-A was the only staff in the room and R120 was not redirected the resident back to the table to eat. R120's care plan dated 4/30/15, indicated R120 fed self after set up and required encouragement to eat at each meal. After the observations at 5:55 p.m. NA-A proceeded to the alcove where the carts were stored and proceeded to straighten up trays. NA-A walked back and forth from the dining room to the carts, placing trays on the carts. A licensed practical nurse (LPN)-C then entered the dining room and explained, "Today we have five dining areas because of 'behaviors.' Usually we have four dining areas." LPN-C said three NAs and the LPN assigned to work on the unit that evening.	F 241		

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F 241	Continued From page 6	F 241		

R92 was handed a glass of milk by NA-C who was standing next to the resident at 6:00 when the surveyor entered the fifth floor north dining room. NA-C then stepped away to redirect another resident, and then returned and stood next to R92 to assist her to eat. NA-C left R92 again to redirect another resident in the room. NA-C then returned to R92 and sat beside R92 to assist the resident to finish her meal.

R92's care plan dated 5/12/15, indicated set up, encourage food and fluids and assist the resident as she allowed.

R34 was unsupervised for five minutes in the dining room at approximately 10:00 a.m. when she wheeled to the edge of the dining room and stated, "I will be right back." NA-F returned to the dining room and moved R34 into a corner in the dining room as she said to R34, "Let's get you out of the way here." NA-F then placed a tray of food in front of R34.

R34's care plan dated 6/17/15, indicated she had a low body mass index, variable oral intake related to dementia and at times refused assistance and meals. Staff was directed to provide observation, encouragement, and to monitor her self-feeding ability and meals and low BMI, meals on unit with observation and encouragement and monitor self feeding ability and follow per nutrition risk.

On 8/5/15, at 1:03 p.m. and on 8/6/15, at 8:30 a.m. the director of nursing was interviewed regarding the dining room situation. She explained she expected staff to sit down with a resident when assisting with meals. Staff also should have assisted no more than two residents

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F 241	Continued From page 7 at one time without interruption, unless there was an emergency. The DON stated that it would have presented a safety issue if residents were left with food and staff were not present, and she would have expected staff to be available to supervise residents. The facility's 8/22/13, Dignity and Respect of Each Resident Policy read, "Dignity is defined as the maintenance of a resident's self-esteem and self-worth. Saint Anne of Winona expects each employee to treat each and every resident with dignity and respect to maintain self-esteem and self-worth for all residents."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 residents (R21) in the sample who required fluid restriction monitoring. In addition, the facility failed to follow the care plan for orthostatic blood pressures monitoring for 2 of 5 residents (R57, R3) reviewed for unnecessary medications. Findings include: R21's care plan dated 7/6/15, identified nutrition	F 282	F282 SS = D Facility has system to ensure policies and procedures that care be provided by qualified persons in accordance with each resident's written plan of care. Facility policy regarding Care Planning was reviewed and found to be appropriate. Facility nursing staff will receive education related to the expectation of following each residents plan of care.	9/15/15

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F 282	Continued From page 8 problem "alteration in nutrition related to end stage renal disease (ESRD), dialysis". The approaches included, "2000 cc fluid restriction; 1400 cc per diet and 600 cc on floor". It also directed staff to "monitor weights, intakes, tolerance of diet and maintain fluid restriction per orders". R21's plan of care was not followed as the fluid intake was not monitored or documented every shift. R21 was observed on 8/5/15, between 8:17 a.m. and 8:28 in the main dining room eating her breakfast. R21 drunk a cup of coffee which was approximately 240 cubic centimeters (cc), a glass of cranberry juice approximately 240 cc and a glass of water with approximation of 240 cc. On 8/5/15, at 9:58 a.m. R21 was observed in her room sitting in her wheelchair. By her bedside table stand was an 8 ounce (oz) glass with an approximate 200 cc of water and another 4 oz glass with about 60 cc of water. When interviewed, R21 stated that she knows that she is on fluid restriction but did not know of how much. She stated, "they just give it to me". On 8/5/15, at 10:06 a.m. a volunteer was observed to be passing water for residents. The volunteer entered R21's room with a glass full of ice water, set it at the bedside table, and came out. The volunteer was interviewed immediately after coming out of R21's room. She stated that she passes water three days a week for second and third floors. She stated that she did not know that R21 was on any fluid restriction since staff did "not let me know". She noted that she has a list of residents who are on "regular and thickened". She verified that she has been leaving a glass of water on R21's room whenever	F 282	R3, R57 and R21's care plans were reviewed and were appropriate or updated R3, R57 have monthly orthostatic B/P prompted/recorded in TAR Review of Fluid Restriction P&P was completed and revisions made Nursing staff education was completed on fluid restriction policy An audit was completed and results reveal every resident taking an antipsychotic has an order for monthly orthostatic B/Ps Review of Hydration Policy was completed and found to be appropriate Policy on water pass was written Update the water pass form on each unit and the HUC will update with each change on the unit and will review it weekly. Volunteers and nursing staff that pass water will be educated on the water pass policy. Audits will be conducted on weekly basis until 11/1/15 to evaluate and ensure effectiveness of plan. Director of Nursing or their designee are responsible for monitoring of this plan of correction.	

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F 282	Continued From page 9 she is volunteering. During medical record review on 8/5/15, no documentation was evident to indicate R21's fluid intake was being monitored and documented as directed by the care plan. R21's physician orders dated 7/31/15, directed staff that R21 was on fluid restriction of 2000 cc per day; 1400 cc from culinary and 600 cc from nursing. The fluid intake record from 7/20/15 through 8/5/15 indicated R21 was taking anywhere from 90 cc to 600 cc a day. However, this did not indicate whether the fluids were from culinary or nursing. The fluid intake record did not reflect every shift documentation, and there were missing documentation on some days and averagely, the documentation was done only once a day per the record. When interviewed on 8/5/15, at nursing assistant (NA)-E stated that R21 eats at the main dining room "downstairs" and wasn't sure who did intake documentation for R21 while eating "downstairs". NA-E also stated that he wasn't aware that R21 was on any fluid restriction. When interviewed on 8/5/15, at 12:46 p.m. licensed practical nurse (LPN)-D stated that dietary provides R21 with 1400 cc of fluids with meals and "we are supposed to give her the rest of 600 cc". LPN-D verified that she does not record the intake anywhere and stated that, " I guess with medication pass it takes care of that". LPN-D also verified that there was no documentation anywhere to indicate that staff was closely monitoring the fluid restriction.	F 282	Completion Date: 9/15/15	

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When interviewed on 8/5/15, at 1:48 p.m., registered nurse (RN)-B verified that there was no accurate monitoring of fluid restriction. RN-B stated that they had an actual order in the treatment record where fluid intake was being recorded every shift, but with R21's hospitalization "I guess we got it missed in between". RN-B stated that she expected that her staff monitored R21's fluid restrictions according to the orders and care plan.

When interviewed on 8/6/15, at 10:14 a.m., director of nursing (DON) stated that her expectation was that staff monitor fluid intake and maintain fluid restriction as per the orders. DON also stated that she expected that there should be a "paper" charting that nursing staff are to be recording fluid intake and totaling it at end of day. She further stated, "My understanding is that we do not have that in place".

A Fluid Restriction Policy dated 11/1/13, directed staff that, "Upon order nursing will enter fluid restriction order into Electronic Medical Record (EMR) placing order into diet category. Standard fluid allocation table will be utilized as tool to guide the dietician in the distribution of fluids throughout a 24 hour period. Large quantities of fluids should not be left at bedside. Fluid allocation will be entered into the EMR. Resident will be placed on daily I/O. weights will be monitored according to MD order. Each shift, nursing staff will monitor, report, document fluid intake and output. At end of each 24 hour period, nursing staff will tally and record documentation of total fluid".

R57's care plan dated 12/24/15, identified

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"potential for alteration in mood and psycho-social well being related to history of dementia and depression" problem, and directed staff to monitor "lying/sitting blood pressure (BP) every day for three days then monthly when antidepressant or antipsychotic medication initiated or dose increased".

R57's electronic medical record (EMR) indicated that R57 was taking medications commonly known to contribute to orthostatic hypertension and/or falls, which included Seroquel (an antipsychotic medication) 25 mg (miligrams) once a day. The medication was started on 12/24/09 at 25 mg, was decreased on 4/16/15 to 12.5 mg once a day and then increased back to 25 mg once a day on 7/30/15. R57 was also prescribed Sertraline (an antidepressant used to manage depression) 150 mg every morning.

R57's progress notes and event reports related to falls revealed that R57 experienced nine falls in the last six months; 7/6/15, 6/6/15, 5/5/15, 4/20/15, 3/25/15, 3/16/15, 3/13/15, 3/11/15 without injuries and 7/5/15 with a skin tear injury to left elbow which measured 1 cm (centimeter) long.

R57's EMR lacked any evidence to indicate that orthostatic BP was being monitored by the nursing staff as directed. Document review of R57's blood pressures results from 5/5/15 to 7/27/15 lacked documentation that staff was performing any orthostatic blood pressures as required.

During an interview on 8/5/15, at 1:44 p.m. a registered nurse (RN)-B verified that there was no orthostatic BP monitoring for R57. RN-B also

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F 282	Continued From page 12 confirmed that R57's care plan directed staff to monitor orthostatic BP every month. RN-B stated that her expectations were nurses to do orthostatic BP every month as directed but "I don't have documentation". RN-B also confirmed that R57 had frequent falls averaging one fall a month. During an interview on 8/6/15, at 10:14 a.m. the director of nursing (DON) stated that they have added orthostatic BP monitoring to "anyone on psychotropic medications". DON stated that her expectations is that nursing staff to follow care plans and that orthostatic BP should be monitored. DON further stated, "if it's ordered and care planned, I expect my nurses to do it". The facility's "Psychopharmacological Drug Therapy policy" dated 3/20/08, directed staff to "Do lying/standing blood pressure every day times three days then monthly for drug initiation and dose increases on residents who are receiving Antipsychotic, Antianxiety, and Antidepressant medication". R3's care plan dated 2/19/15, directed staff to measure orthostatic blood pressures on the 19th of each month due to the use of Zyprexa an psychotropic medication with a care plan initiation date of 6/2/15. R3's progress notes related to falls revealed the resident experienced two falls	F 282		

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F 282	Continued From page 13 without injury on 5/16/15 and 6/25/15. R3's electronic treatment administration record (ETAR) lacked any indications/instructions for nursing staff to monitor R3's orthostatic blood pressure monthly. In addition, there was no evidence the orthostatic blood pressures had ever been taken. During an interview on 8/6/15, at 11:36 a.m. a registered nurse (RN)-A confirmed R3's care plan indicated that he was to have orthostatic blood pressures measured on the 19th day of each month. RN-A, however, was unable to produce documentation showing staff had been monitoring the resident's orthostatic blood pressures. RN-A explained R3's often refused monitoring of orthostatic blood pressures and RN-A said "Yes, we should have done [R3's] blood pressures and document any refusal in a progress note."	F 282		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to incorporate and accurately monitor fluid restriction for 1 of 1 resident (R21) receiving dialysis services and requiring monitoring of fluid intake. Findings include:	F 327	F327 SS = D Facility has system to ensure each resident has sufficient fluid intake to maintain proper hydration and health. Facility policy regarding Fluid Restriction was reviewed and found to be	9/15/15

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F 327	Continued From page 14 R21 was observed wheeling herself toward the elevator and reported she was on her way "downstairs" for breakfast on 8/5/15, at 7:56 a.m. R21 was then observed eating breakfast in the main dining room from 8:17 a.m. and 8:28 a.m. R21 consumed a cup of coffee which was approximately 240 cubic centimeters (ccs), a glass of cranberry juice approximately 240 ccs and a glass of water also approximately 240 ccs (an approximate total of 720 cc's). On 8/5/15, at 9:58 a.m. R21 was observed in her room. On the bedside table stand was an 8 ounce (oz) glass with an approximate 200 ccs of water and another 4 oz glass with about 60 ccs of water. When interviewed, R21 stated that she was aware she was to have her fluids restricted, but did not know the amount. She stated, "They just give it to me." On 8/5/15, at 10:06 a.m. a volunteer was passing water to resident rooms. The volunteer entered R21's room with a glass full of ice water, set it at the bedside table, and then left the room.. The volunteer (V)-A was interviewed immediately after leaving R21's room. She explained she passed water three days a week for second and third floor residents. She said she was unaware R21's fluids were to be restricted, since staff did "not let me know." She noted she had a list of residents who were to receive "regular and thickened" liquids. V-A verified she had been providing R21 with a glass of water each time she had provided residents with water in their rooms. R21 was receiving dialysis treatment three times a week, on Tuesdays, Thursdays and Saturdays for stage 5 chronic kidney disease. An annual Minimum Data Set (MDS) dated 5/7/15, indicated	F 327	appropriate. Facility nursing staff will receive education related to the expectation of following this procedure for any resident with a fluid restriction. Review of Hydration Policy was completed and found to be appropriate. Policy on water pass was written. Update the water pass form on each unit and the HUC will update with each change on the unit and will review it weekly. Volunteers and nursing staff that pass water will be educated on the water pass policy. Audits are being conducted on weekly basis until 11/1/15 to evaluate and ensure effectiveness of plan. Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/15/15	

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R21 was cognitively intact, was receiving dialysis, required extensive assistance with activities of daily living.

R21's care plan dated 7/6/15, identified alteration in nutrition related to end stage renal disease (ESRD), dialysis as a problem. Some of the approaches included: 2000 cc fluid restriction; 1400 ccs per diet and 600 ccs on floor. It also directed staff to monitor weights, intakes, tolerance of diet and maintain fluid restriction per orders. However, the care plan did not address how the 600 ccs was to be administered.

R21's current physician orders dated 7/31/15, directed staff to restrict R21's fluids to 2000 ccs per day with 1400 ccs from culinary (during meals) and 600 ccs from nursing (medication pass and during meals).

The fluid intake record from 7/20/15 through 8/5/15, revealed R21 was consuming anywhere from 90 to 600 ccs a day. However, the documentation did not indicate whether the fluids were from culinary or nursing. The fluid intake record did not reflect every shift documentation, and some days the resident's intake was not documented. Generally, intake was documented the documentation was being recorded once daily.

When interviewed on 8/5/15, at nursing assistant (NA)-E reported R21 ate in the main dining room, but was unsure who monitored and documented the resident's intake while eating "downstairs." NA-E also stated he was unaware whether any resident was supposed to have restricted fluids.

When interviewed on 8/5/15, at 12:46 p.m. a

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licensed practical nurse (LPN)-D stated that dietary staff provided R21 with 1400 ccs of fluids with meals and, "We are supposed to give her the rest of 600 ccs." LPN-D verified that she did not record R21's intake anywhere and stated, " I guess with medication pass it takes care of that." LPN-D also verified that there was no documentation anywhere to support the staff was closely monitoring R21's fluid restriction.

When interviewed on 8/5/15, at 1:48 p.m. a registered nurse (RN)-B verified the staff did not maintain a system of accurately monitoring R21's fluid restriction. RN-B explained that they had an actual order in the treatment record where fluid intake was being recorded every shift, but with R21's hospitalization "I guess we got it missed in between." RN-B stated that she expected that staff would monitor R21's fluid restrictions according to the physician orders and care plan.

The director of nursing stated in an interview on 8/6/15, at 10:14 a.m. that her expectation was that staff monitor fluid intake and maintain fluid restriction for R21 as per the orders. The DON also stated she also would have expected "paper" charting that nursing staff recorded fluid intake and totaled the ccs at end of day. She further stated, "My understanding is that we do not have that in place."

A Fluid Restriction Policy dated 11/1/13, directed staff that, "Upon order nursing will enter fluid restriction order into Electronic Medical Record (EMR) placing order into diet category. Standard fluid allocation table will be utilized as tool to guide the dietician in the distribution of fluids throughout a 24 hour period. Large quantities of fluids should not be left at bedside. Fluid

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F 327	Continued From page 17 allocation will be entered into the EMR. Resident will be placed on daily I/O [intake and output]. weights will be monitored according to MD [physician] order. Each shift, nursing staff will monitor, report, document fluid intake and output. At end of each 24 hour period, nursing staff will tally and record documentation of total fluid."	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		9/15/15

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F 329	Continued From page 18 Based on observation, interview and document review the facility failed to ensure adequate monitoring for orthostatic blood pressures for 2 of 5 residents (R3, R57) reviewed for unnecessary medications. Findings include: R3 was prescribed medications known to contribute to orthostatic hypertension and/or falls including Zyprexa 15 mg (milligrams) at hours of sleep. The medication was initiated on 4/25/14) and was increased to 20 mg on 6/4/15, along with Sinemet (used for Parkinson's disease) 25/250 mg four times daily. R3's care plan dated 2/19/15, directed staff to measure orthostatic blood pressures on the 19th of each month due to the use of Zyprexa an psychotropic medication with a care plan initiation date of 6/2/15. R3's progress notes related to falls revealed the resident experienced two falls without injury on 5/16/15 and 6/25/15. R3's electronic treatment administration record (ETAR) lacked any indications/instructions for nursing staff to monitor R3's orthostatic blood pressure monthly. In addition, there was no evidence the orthostatic blood pressures had ever been taken. During an interview on 8/6/15, at 11:36 a.m. a registered nurse (RN)-A confirmed R3's care plan indicated that he was to have orthostatic blood pressures measured on the 19th day of each month. RN-A, however, was unable to produce documentation showing staff had been monitoring the resident's orthostatic blood pressures. RN-A explained R3's often refused monitoring of orthostatic blood pressures and RN-A said "Yes,	F 329	F329 SS = D Facility has system to ensure each resident¿s drug regimen is free from unnecessary drugs. Residents that have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs Facility policy regarding Use of Psychopharmocologic Medications was reviewed and updated. Facility licensed nursing staff will receive education related to the expectation of following the policy. Licensed nursing staff to review changes to Policy and sign off Provide education for all licensed nursing staff related to use of and monitoring of psychoactive medications R3 and R57 have monthly orthostatic B/P prompted/recorded in TAR Any resident on and antipsychotic has monthly orthostatic B/P¿s per P&P prompted/recorded in TAR Pharmacy consultant will track and report on at Quarterly Quality Council Meeting	

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F 329	Continued From page 19 we should have done [R3's] blood pressures and document any refusal in a progress note." R57 was observed on 8/5/15, between 7:23 a.m. and 9:52 a.m. in her room lying on her bed. R57 was also observed later in day at 2:29 p.m. sitting in the common area, then as she ambulated with a walker to the elevator assisted by a staff member. R57's electronic medical record (EMR) indicated that R57 was taking medications commonly known to contribute to orthostatic hypertension and/or falls, which included Seroquel (an antipsychotic medication) 25 mg once a day. The medication was started on 12/24/09 at 25 mg, was decreased on 4/16/15 to 12.5 mg once a day and then increased back to 25 mg once a day on 7/30/15. R57 was also prescribed Sertraline (an antidepressant used to manage depression) 150 mg every morning. R57's care plan dated 12/24/15, identified "potential for alteration in mood and psycho-social well being" problem, and directed staff to monitor "lying/sitting blood pressure (BP) every day times three days then monthly when antidepressant or antipsychotic medication initiated or dose increased". R57's progress notes and event reports related to falls revealed that R57 experienced nine falls in the previous six months on 7/6/15, 6/6/15, 5/5/15, 4/20/15, 3/25/15, 3/16/15, 3/13/15, 3/11/15 without injuries and 7/5/15 with a skin tear injury to left elbow which measured 1 centimeter in length.	F 329	Audits being conducted on weekly basis until 11/1/15 to evaluate and ensure effectiveness of plan. Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/15/15	

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F 329	Continued From page 20 R57's EMR lacked any evidence to indicate that orthostatic BP was being monitored by the nursing staff as directed. Document review of R57's blood pressures results from 5/5/15 to 7/27/15 lacked any supporting documentation that staff had been performing any orthostatic blood pressures as required. During an interview on 8/5/15, at 1:44 p.m. RN-B verified no orthostatic blood pressures had been monitored for R57. RN-B also confirmed that R57's care plan directed staff to monitor orthostatic BP every month. RN-B stated that her expectations were that nursing staff would complete orthostatic BP's every month as directed, but "I don't have documentation". RN-B also confirmed that R57 had frequent falls averaging one fall a month. During an interview on 8/6/15, at 10:14 a.m. the director of nursing (DON) stated that they had added orthostatic BP monitoring to "anyone on psychotropic medications". The DON stated that her expectation was that nursing staff would follow resident care plans and that orthostatic BP should be monitored. The DON further stated, "If it's ordered and care planned, I expect my nurses to do it". A 3/20/08 Psychopharmacological Drug Therapy policy directed staff to "Do lying/standing blood pressure every day times three days then monthly for drug initiation and dose increases on residents who are receiving Antipsychotic, Antianxiety, and Antidepressant medication".	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		9/15/15

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F 428	Continued From page 21 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified the need for ongoing monitoring for orthostatic blood pressures of antipsychotic medications for 2 of 5 residents (R3, R57) reviewed for unnecessary medications. Findings include: R3's physician orders dated 6/9/15, indicated R3 was prescribed an antipsychotic medication Zyprexa 15 mg (milligrams) at HS (hours of sleep) with a start date of 4/25/14 and was increased to 20 mg on 6/4/15. In additions, R3 was prescribed other medications know to potentially contribute to orthostatic hypertension and/or falls including Sinemet used for Parkinson's disease (antidepressant commonly used to promote sleep). R3's care plan dated 2/19/15, indicated R3 had a history of falls and alteration in mood/thought process related to history of depression. The goal was for the resident to "be free from falls/injury and remain safe in his daily	F 428	F428 SS = D Facility has system to ensure the drug regimen of each residents is reviewed at least once a month by a licensed pharmacist. The pharmacist reports any irregularities to the attending physical, and the director of nursing, and these reports must be acted upon. Facility policy regarding Use of Psychopharmocologic Medications was reviewed and updated. Facility licensed nursing staff will receive education related to the expectation of following the policy. Facility policy regarding Monitoring of medications by a pharmacist was reviewed and found to be appropriate. Facility licensed nursing staff will receive education related to the expectation of following the policy. Care plans for R3 and R57 reviewed and appropriate. Residents R3 and R57 have	

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F 428	Continued From page 22 environment." The interventions for the resident was to have orthostatic blood pressure measured on the 19th day of each month due to being on Zyprexa an psychotropic medication with a start date of 4/25/14, however, there was no evidence the orthostatic blood pressures had ever been taken. R3's progress notes related to falls revealed the resident experienced two falls on 5/16/15 and 6/25/15, resident did not sustain any injuries. During an interview on 8/6/15, at 11:36 a.m. registered nurse (RN)-A confirmed that R3's care plan indicated that he was to have orthostatic blood pressures monitored on the 19th of each month due to being on an antipsychotic medication. RN-A could not produce any documentation showing that staff was monitoring R3's orthostatic blood pressures monthly per his care plan. RN-A explained R3's often refused monitoring, but said, "Yes, we should have done [R3's] blood pressures and documented any refusal in a progress note." Document review of R3's blood pressures results from 2/19/15 to 7/31/15 lacked documentation that staff was performing any orthostatic blood pressures as required. A phone interview conducted on 8/7/15, at 10:21 a.m. with the facility's consultant pharmacist (CP) stated she was familiar with R3's medical regime and came to the facility monthly. The CP explained the facility had a policy that when a resident was prescribed antipsychotic medication, orthostatic BPs would be measured monthly. She had not, however, check to see R3's BPs were being taken monthly. Instead, the CP stated she reviewed the data if the facility informed her a	F 428	monthly orthostatic B/P prompted/ recorded in TAR. Audits are being conducted on weekly basis until 11/1/15 to evaluate and ensure effectiveness of plan of correction. Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/3/15	

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F 428	Continued From page 23	F 428		

resident was falling or experienced a change in condition. The CP was unaware that R3 had sustained two falls.

R57's physician orders dated 8/5/15 indicated R57 was prescribed an antipsychotic medication Seroquel (an antipsychotic medication) 25 mg (miligrams) once a day. The medication was started on 12/24/09 at 25 mg once a day, then decreased on 4/16/15 to 12.5 mg once a day and then increased back to 25 mg once a day on 7/30/15. R57 was also prescribed Sertraline (an antidepressant used to manage depression) 150 mg every morning. Both medications are known to potentially contribute to orthostatic hypertension and lead to falls.

R57's care plan dated 9/27/10, identified "risk for falls related to history of falls, and on psychotropic medication and assistance with transfers, bed mobility and ambulation at times" problem. The goal was "falls will be avoided and safety will be maintained". The approach, among others was to measure "lying/sitting blood pressure (BP) every day, for three days then monthly when antidepressant or antipsychotic medication initiated or dose increased". However, there was no evidence indicating that orthostatic blood pressure was being monitored, or even ever been taken before.

R57's progress notes and event reports related to falls revealed that R57 experienced nine falls in the last six months; 7/6/15, 6/6/15, 5/5/15, 4/20/15, 3/25/15, 3/16/15, 3/13/15, 3/11/15 without injuries and with a skin tear to the elbow on 7/5/15.

Document review of R57's blood pressures

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 24	F 428		

results from 5/5/15 to 7/27/15 lacked documentation that staff was performing any orthostatic blood pressures as required. R57's EMR lacked any evidence to indicate that orthostatic BP was being monitored by the nursing staff as directed.

During an interview on 8/5/15, at 1:44 p.m. a registered nurse (RN)-B verified that there was no orthostatic BP monitoring for R57. RN-B also confirmed that R57's care plan directed staff to monitor orthostatic BP every month. RN-B stated that her expectations were nurses to do orthostatic BP every month as directed but "I don't have documentation". RN-B also confirmed that R57 had frequent falls averaging one fall a month.

During a phone interview on 8/5/15, at 2:38 p.m. the facility's CP stated an attempt at reducing and eventually discontinuing Seroquel for R57 had been tried and failed. The CP stated that she usually looked at the fall assessment level of a resident and then recommended orthostatic BPs based on that, but "I haven't seen anything with [R57] that would make me recommend orthostatic BPs," and the facility had not reported frequent falls.

During an interview on 8/6/15, at 10:14 a.m. the director of nursing (DON) stated that they have added orthostatic BP monitoring for "anyone on psychotropic medications". The DON stated that her expectations is that nursing staff to follow care plans and that orthostatic BPs should be monitored. The DON further stated, "If it's ordered and care planned, I expect my nurses to do it".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING _____ B. WING _____	08/06/2015

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F 428	Continued From page 25 The facility's 2/15, Consultant Pharmacist Services Provider Requirements policy indicated that the CP "will collaborate with the facility staff to help identify, communicate, address and resolve concerns and issues related to provision of pharmaceutical services. The [CP] will review the medication regimen for each resident at least monthly, communicate to the facility leadership of any potential finding related to medication monitoring."	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		9/15/15

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F 431	Continued From page 26 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled accurately for 2 of 25 medications observed for 2 of 6 residents (R33, R30) during medication administration. Findings include: R33 was prescribed Centrum (multivitamin) 15 milliliters (ml) to be administered by mouth via a gastrostomy tube (feeding tube). During an observation on 8/5/15, at 7:05 a.m. a licensed practical nurse (LPN)-F administered the Centrum via the feeding tube. Following the observation, LPN-F verified R33 did not receive any medications by mouth. LPN-F also verified the label instructed staff to administer the medication "by mouth." LPN-F then placed a Change of Directions sticker on the medication in order to alert staff, and said she would be the label corrected. R30 was prescribed Lantus insulin 12 units every morning. In an observation on 8/5/15, at 8:30 a.m. LPN-D drew up 17 units and explained she believed a medication order change had occurred the night before. LPN-D Verified that the medication should have been labeled with a	F 431	F431 SS = D Facility has system to employ or obtain the services of a licensed pharmacist consultant. Drugs and biologicals used in the facility must be labeled in accordance to ensure the drug regimen of each residents is reviewed at least once a month by a licensed pharmacist. The pharmacist reports any irregularities to the attending physical, and the director of nursing, and these reports must be acted upon. Facility policy on labeling medications and biologicals was reviewed and found to be appropriate. Licensed nursing staff received education related to correct labeling, dates and storage of medications at meetings held on 8/17/15, 8/18/15, 8/28/15, 8/12/15. Review of R33 and R 30 Care plan was reviewed and appropriate Audits being conducted on weekly basis	

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F 431	Continued From page 27 sticker indicating the order change. LPN-D proceeded to label the medication with the order change sticker. In an interview with the director of nursing on 8/5/15, at 12:05 p.m. it was explained nursing staff had "change order stickers" available on the medication carts, and should have been using them to indicate changes until updated labeled medication was obtained. When interviewed on 8/7/15, at 1:21 p.m., the facility's consultant pharmacist (CP)-A explained the facility should have utilized a direction change sticker should the route have been changed, for example, from oral to gastrostomy tube. She stated that the medication label should have matched the route given. Furthermore, the pharmacist stated that when there is a change in a medication order, the facility needed to send a fax to the pharmacy indicating the order change. The 4/19/10 Medication Labels policy read, "All medications needed to be labeled properly to ensure proper administration of medications. Each prescription medication label should include: resident's name; specific directions for use, including route of administration; strength of medication; prescription number; the name of prescribing practitioner; directions for use; name of pharmacy filling the drug order; date medication is dispensed. Further, the policy stated that if the physician's directions for use change or the pharmacy types an error on the label and it is impractical to return the medication to the pharmacy for re-labeling, the nurse places a signal label on the container indicating that there is a change in directions for use. The provider pharmacy is informed prior to the next	F 431	until 11/1/15 to evaluate and ensure effectiveness of plan. Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/15/15	

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F 431	Continued From page 28 refill so the new container will show a corrected label."	F 431		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Saint Anne Extended Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/02/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Saint Anne Extended Healthcare Center is a 6-story building with no basement. The facility was constructed in 1962 and was determined to be of Type II(222) construction. The facility is fully sprinkled and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 100 beds at the time of the survey.	K 000		
K 011 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a	K 011		8/18/15

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K 011	Continued From page 2 nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour fire rated construction at building separation wall in accordance with 2000 - NFPA 101, sections 19.1.1.4.1. The deficient practice could affect 30 out of 100 residents. Findings include: On facility tour between 10:00 AM and 1:45 PM 08/18/2015, observation revealed, that the 2 hour fire rated building separation wall between the nursing home and assisted living has a open penetration around the fire alarm cable above the lay in ceiling. This deficient practice was confirmed by the Administrator (JB) at the time of discovery.	K 011	Plan developed to inspect and address any penetrations along the 2-hour fire rated construction at building separation. Penetrations will be caulked with Metacualk 1000. Maintenance Director and/or designee responsible for monitoring of this plan of correction.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029		8/18/15

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K 029	Continued From page 3 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out 100 residents. Findings include: On facility tour between 10:00 AM and 1:45 PM 08/18/2015, observation revealed, that the following was found: 1. Basement - Laundry room #12 (over 100 sq ft) the entrance door will not shut and latch 2. Basement - Laundry Folding room (over 50 sq ft) a. No automatic door closer b. Door being propped open c. Open penetration below drop in ceiling around sprinkler line These deficient practices were confirmed by the Administrator (JB) at the time of discovery.	K 029	Plan developed to address each item identified. Laundry room door to be planed to ensure latches automatically and securely when shut. Folding Room door latch mechanism removed from door and door closure mechanism added. Penetrations around drop in ceiling around sprinkler will be filled with fire rated caulk - Metacaulk 1000. Maintenance Director and/or designee responsible for monitoring of this plan of correction.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		8/18/15

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K 062	Continued From page 4 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7 and 1998 NFPA 25. Findings include: On facility tour between 10:00 AM and 1:45 PM 08/18/2015, observation revealed the following: 1. Observation revealed that the spare sprinkler head box does not contain 2 spare fire sprinkler heads for each type head in the facility 2. Fire Pump packing is bad and it was also noted on the annual sprinkler report from General Sprinkler on 4/13/15. At the time of this inspection the above have not been corrected. These deficient practices were confirmed by the Administrator (JB) at the time of discovery.	K 062	General Sprinkler contacted and will be coming to facility to review contents of sprinkler head box and ensure appropriate number of each sprinkler head type are available. General Sprinkler will also address fire pump packing at that time. General Sprinkler indicates this work will be completed by 9/15/15. Maintenance Director and/or designee responsible for monitoring of this plan of correction.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all	K 064		9/4/15

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K 064	Continued From page 5 health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to maintain portable fire extinguisher in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. This deficient practice could affect 10 out of 100 residents. Findings include: On facility tour between 10:00 AM and 1:45 PM 08/18/2015, observation reveal that in the basement conference room # 30, the fire extinguisher has not been annual inspected since 1/2014 This deficient practice was confirmed by the Administrator (JB) at the time of discovery.	K 064	Fire extinguisher located in basement conference room #30 has been reviewed. Checklist has been created for use by Summit when they are in the building to ensure all fire extinguishers are inspected and signed off on. Maintenance Director and/or designee is responsible for monitoring of this plan of correction.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		9/4/15

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K 076	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Sections 4-3.5.2.2 (2) and 8-3.1.11.2. This deficient practice could all 15 out of 100 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:45 PM 08/18/2015, observation revealed that the 2nd floor west oxygen storage room found the following: 1. Empty cardboard boxes being stored in room 2. One "E" cylinder not secured 3. Empty and full "E" cylinders intermingled This deficient practice was confirmed by the Administrator (JB) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 076	Contents and organization of oxygen storage rooms reviewed. Empty cardboard boxes were removed from storage area. "E" cylinder was properly secured. Empty / full cylinders were divided per code. Maintenance Director and/or designee responsible for monitoring of this plan of correction.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
August 25, 2015

Ms. Jodi Barton, Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, Minnesota 55987

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5233025

Dear Ms. Barton:

The above facility was surveyed on August 3, 2015 through August 6, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact **Gary Nederhoff, (507) 206-2731 .**

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00955	A. BUILDING: _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 3rd to August 6th, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000		

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2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		9/15/15

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2 565	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 residents (R21) in the sample who required fluid restriction monitoring. In addition, the facility failed to follow the care plan for orthostatic blood pressures monitoring for 2 of 5 residents (R57, R3) reviewed for unnecessary medications. Findings include: R21's care plan dated 7/6/15, identified nutrition problem "alteration in nutrition related to end stage renal disease (ESRD), dialysis". The approaches included, "2000 cc fluid restriction; 1400 cc per diet and 600 cc on floor". It also directed staff to "monitor weights, intakes, tolerance of diet and maintain fluid restriction per orders". R21's plan of care was not followed as the fluid intake was not monitored or documented every shift. R21 was observed on 8/5/15, between 8:17 a.m. and 8:28 in the main dining room eating her breakfast. R21 drunk a cup of coffee which was approximately 240 cubic centimeters (cc), a glass of cranberry juice approximately 240 cc and a glass of water with approximation of 240 cc. On 8/5/15, at 9:58 a.m. R21 was observed in her room sitting in her wheelchair. By her bedside table stand was an 8 ounce (oz) glass with an approximate 200 cc of water and another 4 oz glass with about 60 cc of water. When	2 565	Facility has system to ensure policies and procedures that care be provided by qualified persons in accordance with each resident¿s written plan of care. Facility policy regarding Care Planning was reviewed and found to be appropriate. Facility nursing staff will receive education related to the expectation of following each residents plan of care. R3, R57 and R21¿s care plans were reviewed and were appropriate or updated R3, R57 have monthly orthostatic B/P prompted/recorded in TAR Review of Fluid Restriction P&P was completed and revisions made Nursing staff education was completed on fluid restriction policy An audit was completed and every resident taking and antipsychotic has an order for monthly orthostatic B/P¿s Review of Hydration Policy was completed and found to be appropriate Policy on water pass was written Update the water pass form on each unit and the HUC will update with each change on the unit and will review it weekly.	

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2 565	Continued From page 3 interviewed, R21 stated that she knows that she is on fluid restriction but did not know of how much. She stated, "they just give it to me". On 8/5/15, at 10:06 a.m. a volunteer was observed to be passing water for residents. The volunteer entered R21's room with a glass full of ice water, set it at the bedside table, and came out. The volunteer was interviewed immediately after coming out of R21's room. She stated that she passes water three days a week for second and third floors. She stated that she did not know that R21 was on any fluid restriction since staff did "not let me know". She noted that she has a list of residents who are on "regular and thickened". She verified that she has been leaving a glass of water on R21's room whenever she is volunteering. During medical record review on 8/5/15, no documentation was evident to indicate R21's fluid intake was being monitored and documented as directed by the care plan. R21's physician orders dated 7/31/15, directed staff that R21 was on fluid restriction of 2000 cc per day; 1400 cc from culinary and 600 cc from nursing. The fluid intake record from 7/20/15 through 8/5/15 indicated R21 was taking anywhere from 90 cc to 600 cc a day. However, this did not indicate whether the fluids were from culinary or nursing. The fluid intake record did not reflect every shift documentation, and there were missing documentation on some days and averagely, the documentation was done only once a day per the record. When interviewed on 8/5/15, at nursing assistant	2 565	Volunteers and nursing staff that pass water will be educated on the water pass policy Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/15/15	

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2 565	Continued From page 4 (NA)-E stated that R21 eats at the main dining room "downstairs" and wasn't sure who did intake documentation for R21 while eating "downstairs". NA-E also stated that he wasn't aware that R21 was on any fluid restriction. When interviewed on 8/5/15, at 12:46 p.m. licensed practical nurse (LPN)-D stated that dietary provides R21 with 1400 cc of fluids with meals and "we are supposed to give her the rest of 600 cc". LPN-D verified that she does not record the intake anywhere and stated that, " I guess with medication pass it takes care of that". LPN-D also verified that there was no documentation anywhere to indicate that staff was closely monitoring the fluid restriction. When interviewed on 8/5/15, at 1:48 p.m., registered nurse (RN)-B verified that there was no accurate monitoring of fluid restriction. RN-B stated that they had an actual order in the treatment record where fluid intake was being recorded every shift, but with R21's hospitalization "I guess we got it missed in between". RN-B stated that she expected that her staff monitored R21's fluid restrictions according to the orders and care plan. When interviewed on 8/6/15, at 10:14 a.m., director of nursing (DON) stated that her expectation was that staff monitor fluid intake and maintain fluid restriction as per the orders. DON also stated that she expected that there should be a "paper" charting that nursing staff are to be recording fluid intake and totaling it at end of day. She further stated, "My understanding is that we do not have that in place". A Fluid Restriction Policy dated 11/1/13, directed staff that, "Upon order nursing will enter fluid	2 565		

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2 565	Continued From page 5	2 565		

restriction order into Electronic Medical Record (EMR) placing order into diet category. Standard fluid allocation table will be utilized as tool to guide the dietician in the distribution of fluids throughout a 24 hour period. Large quantities of fluids should not be left at bedside. Fluid allocation will be entered into the EMR. Resident will be placed on daily I/O. weights will be monitored according to MD order. Each shift, nursing staff will monitor, report, document fluid intake and output. At end of each 24 hour period, nursing staff will tally and record documentation of total fluid".

R57's care plan dated 12/24/15, identified "potential for alteration in mood and psycho-social well being related to history of dementia and depression" problem, and directed staff to monitor "lying/sitting blood pressure (BP) every day for three days then monthly when antidepressant or antipsychotic medication initiated or dose increased".

R57's electronic medical record (EMR) indicated that R57 was taking medications commonly known to contribute to orthostatic hypertension and/or falls, which included Seroquel (an antipsychotic medication) 25 mg (miligrams) once a day. The medication was started on 12/24/09 at 25 mg, was decreased on 4/16/15 to 12.5 mg once a day and then increased back to 25 mg once a day on 7/30/15. R57 was also prescribed Sertraline (an antidepressant used to manage depression) 150 mg every morning.

R57's progress notes and event reports related to falls revealed that R57 experienced nine falls in the last six months; 7/6/15, 6/6/15, 5/5/15, 4/20/15, 3/25/15, 3/16/15, 3/13/15, 3/11/15 without injuries and 7/5/15 with a skin tear injury

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2 565	Continued From page 6 to left elbow which measured 1 cm (centimeter) long. R57's EMR lacked any evidence to indicate that orthostatic BP was being monitored by the nursing staff as directed. Document review of R57's blood pressures results from 5/5/15 to 7/27/15 lacked documentation that staff was performing any orthostatic blood pressures as required. During an interview on 8/5/15, at 1:44 p.m. a registered nurse (RN)-B verified that there was no orthostatic BP monitoring for R57. RN-B also confirmed that R57's care plan directed staff to monitor orthostatic BP every month. RN-B stated that her expectations were nurses to do orthostatic BP every month as directed but "I don't have documentation". RN-B also confirmed that R57 had frequent falls averaging one fall a month. During an interview on 8/6/15, at 10:14 a.m. the director of nursing (DON) stated that they have added orthostatic BP monitoring to "anyone on psychotropic medications". DON stated that her expectations is that nursing staff to follow care plans and that orthostatic BP should be monitored. DON further stated, "if it's ordered and care planned, I expect my nurses to do it". The facility's "Psychopharmacological Drug Therapy policy" dated 3/20/08, directed staff to "Do lying/standing blood pressure every day times three days then monthly for drug initiation and dose increases on residents who are receiving Antipsychotic, Antianxiety, and Antidepressant medication". R3's care plan dated 2/19/15, directed staff to	2 565		

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2 565	Continued From page 7	2 565		

measure orthostatic blood pressures on the 19th of each month due to the use of Zyprexa an psychotropic medication with a care plan initiation date of 6/2/15. R3's progress notes related to falls revealed the resident experienced two falls without injury on 5/16/15 and 6/25/15.

R3's electronic treatment administration record (ETAR) lacked any indications/instructions for nursing staff to monitor R3's orthostatic blood pressure monthly. In addition, there was no evidence the orthostatic blood pressures had ever been taken.

During an interview on 8/6/15, at 11:36 a.m. a registered nurse (RN)-A confirmed R3's care plan indicated that he was to have orthostatic blood pressures measured on the 19th day of each month. RN-A, however, was unable to produce documentation showing staff had been monitoring the resident's orthostatic blood pressures. RN-A explained R3's often refused monitoring of orthostatic blood pressures and RN-A said "Yes, we should have done [R3's] blood pressures and document any refusal in a progress note."

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 940	Continued From page 8	2 940		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to incorporate and accurately monitor fluid restriction for 1 of 1 resident (R21) receiving dialysis services and requiring monitoring of fluid intake. Findings include: R21 was observed wheeling herself toward the elevator and reported she was on her way "downstairs" for breakfast on 8/5/15, at 7:56 a.m. R21 was then observed eating breakfast in the main dining room from 8:17 a.m. and 8:28 a.m. R21 consumed a cup of coffee which was approximately 240 cubic centimeters (ccs), a glass of cranberry juice approximately 240 ccs and a glass of water also approximately 240 ccs (an approximate total of 720 cc's). On 8/5/15, at 9:58 a.m. R21 was observed in her room. On the bedside table stand was an 8 ounce (oz) glass with an approximate 200 ccs of water and another 4 oz glass with about 60 ccs of water. When interviewed, R21 stated that she was aware she was to have her fluids restricted, but did not know the amount. She stated, "They just give it to me." On 8/5/15, at 10:06 a.m. a volunteer was passing water to resident rooms. The volunteer entered	2 940	Facility has system to ensure each resident has sufficient fluid intake to maintain proper hydration and health. Facility policy regarding Fluid Restriction was reviewed and found to be appropriate. Facility nursing staff will receive education related to the expectation of following this procedure for any resident with a fluid restriction. Review of Hydration Policy was completed and found to be appropriate. Policy on water pass was written. Update the water pass form on each unit and the HUC will update with each change on the unit and will review it weekly. Volunteers and nursing staff that pass water will be educated on the water pass policy. Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/15/15	9/15/15

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2 940	Continued From page 9 R21's room with a glass full of ice water, set it at the bedside table, and then left the room.. The volunteer (V)-A was interviewed immediately after leaving R21's room. She explained she passed water three days a week for second and third floor residents. She said she was unaware R21's fluids were to be restricted, since staff did "not let me know." She noted she had a list of residents who were to receive "regular and thickened" liquids. V-A verified she had been providing R21 with a glass of water each time she had provided residents with water in their rooms. R21 was receiving dialysis treatment three times a week, on Tuesdays, Thursdays and Saturdays for stage 5 chronic kidney disease. An annual Minimum Data Set (MDS) dated 5/7/15, indicated R21 was cognitively intact, was receiving dialysis, required extensive assistance with activities of daily living. R21's care plan dated 7/6/15, identified alteration in nutrition related to end stage renal disease (ESRD), dialysis as a problem. Some of the approaches included: 2000 cc fluid restriction; 1400 ccs per diet and 600 ccs on floor. It also directed staff to monitor weights, intakes, tolerance of diet and maintain fluid restriction per orders. However, the care plan did not address how the 600 ccs was to be administered. R21's current physician orders dated 7/31/15, directed staff to restrict R21's fluids to 2000 ccs per day with 1400 ccs from culinary (during meals) and 600 ccs from nursing (medication pass and during meals). The fluid intake record from 7/20/15 through 8/5/15, revealed R21 was consuming anywhere from 90 to 600 ccs a day. However, the	2 940		

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2 940	Continued From page 10 documentation did not indicate whether the fluids were from culinary or nursing. The fluid intake record did not reflect every shift documentation, and some days the resident's intake was not documented. Generally, intake was documented the documentation was being recorded once daily. When interviewed on 8/5/15, at nursing assistant (NA)-E reported R21 ate in the main dining room, but was unsure who monitored and documented the resident's intake while eating "downstairs." NA-E also stated he was unaware whether any resident was supposed to have restricted fluids. When interviewed on 8/5/15, at 12:46 p.m. a licensed practical nurse (LPN)-D stated that dietary staff provided R21 with 1400 ccs of fluids with meals and, "We are supposed to give her the rest of 600 ccs." LPN-D verified that she did not record R21's intake anywhere and stated, " I guess with medication pass it takes care of that." LPN-D also verified that there was no documentation anywhere to support the staff was closely monitoring R21's fluid restriction. When interviewed on 8/5/15, at 1:48 p.m. a registered nurse (RN)-B verified the staff did not maintain a system of accurately monitoring R21's fluid restriction. RN-B explained that they had an actual order in the treatment record where fluid intake was being recorded every shift, but with R21's hospitalization "I guess we got it missed in between." RN-B stated that she expected that staff would monitor R21's fluid restrictions according to the physician orders and care plan. The director of nursing stated in an interview on 8/6/15, at 10:14 a.m. that her expectation was that staff monitor fluid intake and maintain fluid	2 940		

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2 940	Continued From page 11 restriction for R21 as per the orders. The DON also stated she also would have expected "paper" charting that nursing staff recorded fluid intake and totaled the ccs at end of day. She further stated, "My understanding is that we do not have that in place." A Fluid Restriction Policy dated 11/1/13, directed staff that, "Upon order nursing will enter fluid restriction order into Electronic Medical Record (EMR) placing order into diet category. Standard fluid allocation table will be utilized as tool to guide the dietician in the distribution of fluids throughout a 24 hour period. Large quantities of fluids should not be left at bedside. Fluid allocation will be entered into the EMR. Resident will be placed on daily I/O [intake and output]. weights will be monitored according to MD [physician] order. Each shift, nursing staff will monitor, report, document fluid intake and output. At end of each 24 hour period, nursing staff will tally and record documentation of total fluid." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revice policies and procedures related to dialysis fluid restrictions and could provide staff related education. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 940		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy.	21530		9/15/15

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21530	Continued From page 12 This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21530	Facility has system to ensure the drug	

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	00955	A. BUILDING: _____ B. WING _____	08/06/2015

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21530	Continued From page 13 facility failed to ensure the consultant pharmacist identified the need for ongoing monitoring for orthostatic blood pressures of antipsychotic medications for 2 of 5 residents (R3, R57) reviewed for unnecessary medications. Findings include: R3's physician orders dated 6/9/15, indicated R3 was prescribed an antipsychotic medication Zyprexa 15 mg (milligrams) at HS (hours of sleep) with a start date of 4/25/14 and was increased to 20 mg on 6/4/15. In additions, R3 was prescribed other medications know to potentially contribute to orthostatic hypertension and/or falls including Sinemet used for Parkinson's disease (antidepressant commonly used to promote sleep). R3's care plan dated 2/19/15, indicated R3 had a history of falls and alteration in mood/thought process related to history of depression. The goal was for the resident to "be free from falls/injury and remain safe in his daily environment." The interventions for the resident was to have orthostatic blood pressure measured on the 19th day of each month due to being on Zyprexa an psychotropic medication with a start date of 4/25/14, however, there was no evidence the orthostatic blood pressures had ever been taken. R3's progress notes related to falls revealed the resident experienced two falls on 5/16/15 and 6/25/15, resident did not sustain any injuries. During an interview on 8/6/15, at 11:36 a.m. registered nurse (RN)-A confirmed that R3's care plan indicated that he was to have orthostatic blood pressures monitored on the 19th of each month due to being on an antipsychotic	21530	regimen of each residents is reviewed at least once a month by a licensed pharmacist. The pharmacist reports any irregularities to the attending physical, and the director of nursing, and these reports must be acted upon. Facility policy regarding Use of Psychopharmocologic Medications was reviewed and updated. Facility licensed nursing staff will receive education related to the expectation of following the policy. Facility policy regarding Monitoring of medications by a pharmacist was reviewed and found to be appropriate. Facility licensed nursing staff will receive education related to the expectation of following the policy. Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/3/15	

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21530	Continued From page 14	21530		

medication. RN-A could not produce any documentation showing that staff was monitoring R3's orthostatic blood pressures monthly per his care plan. RN-A explained R3's often refused monitoring, but said, "Yes, we should have done [R3's] blood pressures and documented any refusal in a progress note."

Document review of R3's blood pressures results from 2/19/15 to 7/31/15 lacked documentation that staff was performing any orthostatic blood pressures as required.

A phone interview conducted on 8/7/15, at 10:21 a.m. with the facility's consultant pharmacist (CP) stated she was familiar with R3's medical regime and came to the facility monthly. The CP explained the facility had a policy that when a resident was prescribed antipsychotic medication, orthostatic BPs would be measured monthly. She had not, however, check to see R3's BPs were being taken monthly. Instead, the CP stated she reviewed the data if the facility informed her a resident was falling or experienced a change in condition. The CP was unaware that R3 had sustained two falls.

R57's physician orders dated 8/5/15 indicated R57 was prescribed an antipsychotic medication Seroquel (an antipsychotic medication) 25 mg (miligrams) once a day. The medication was started on 12/24/09 at 25 mg once a day, then decreased on 4/16/15 to 12.5 mg once a day and then increased back to 25 mg once a day on 7/30/15. R57 was also prescribed Sertraline (an antidepressant used to manage depression) 150 mg every morning. Both medications are known to potentially contribute to orthostatic hypertension and lead to falls.

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21530	Continued From page 15 R57's care plan dated 9/27/10, identified "risk for falls related to history of falls, and on psychotropic medication and assistance with transfers, bed mobility and ambulation at times" problem. The goal was "falls will be avoided and safety will be maintained". The approach, among others was to measure "lying/sitting blood pressure (BP) every day, for three days then monthly when antidepressant or antipsychotic medication initiated or dose increased". However, there was no evidence indicating that orthostatic blood pressure was being monitored, or even ever been taken before. R57's progress notes and event reports related to falls revealed that R57 experienced nine falls in the last six months; 7/6/15, 6/6/15, 5/5/15, 4/20/15, 3/25/15, 3/16/15, 3/13/15, 3/11/15 without injuries and with a skin tear to the elbow on 7/5/15. Document review of R57's blood pressures results from 5/5/15 to 7/27/15 lacked documentation that staff was performing any orthostatic blood pressures as required. R57's EMR lacked any evidence to indicate that orthostatic BP was being monitored by the nursing staff as directed. During an interview on 8/5/15, at 1:44 p.m. a registered nurse (RN)-B verified that there was no orthostatic BP monitoring for R57. RN-B also confirmed that R57's care plan directed staff to monitor orthostatic BP every month. RN-B stated that her expectations were nurses to do orthostatic BP every month as directed but "I don't have documentation". RN-B also confirmed that R57 had frequent falls averaging one fall a month.	21530		

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21530	Continued From page 16 During a phone interview on 8/5/15, at 2:38 p.m. the facility's CP stated an attempt at reducing and eventually discontinuing Seroquel for R57 had been tried and failed. The CP stated that she usually looked at the fall assessment level of a resident and then recommended orthostatic BPs based on that, but "I haven't seen anything with [R57] that would make me recommend orthostatic BPs," and the facility had not reported frequent falls. During an interview on 8/6/15, at 10:14 a.m. the director of nursing (DON) stated that they have added orthostatic BP monitoring for "anyone on psychotropic medications". The DON stated that her expectations is that nursing staff to follow care plans and that orthostatic BPs should be monitored. The DON further stated, "If it's ordered and care planned, I expect my nurses to do it". The facility's 2/15, Consultant Pharmacist Services Provider Requirements policy indicated that the CP "will collaborate with the facility staff to help identify, communicate, address and resolve concerns and issues related to provision of pharmaceutical services. The [CP] will review the medication regimen for each resident at least monthly, communicate to the facility leadership of any potential finding related to medication monitoring." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication	21530		

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21530	Continued From page 17 reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate monitoring for orthostatic blood pressures for 2 of 5 residents (R3, R57) reviewed for unnecessary	21535	Facility has system to ensure each resident¿s drug regimen is free from unnecessary drugs. Residents that have not used antipsychotic drugs are not given	9/15/15

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21535	Continued From page 18 medications. Findings include: R3 was prescribed medications known to contribute to orthostatic hypertension and/or falls including Zyprexa 15 mg (milligrams) at hours of sleep. The medication was initiated on 4/25/14) and was increased to 20 mg on 6/4/15, along with Sinemet (used for Parkinson's disease) 25/250 mg four times daily. R3's care plan dated 2/19/15, directed staff to measure orthostatic blood pressures on the 19th of each month due to the use of Zyprexa an psychotropic medication with a care plan initiation date of 6/2/15. R3's progress notes related to falls revealed the resident experienced two falls without injury on 5/16/15 and 6/25/15. R3's electronic treatment administration record (ETAR) lacked any indications/instructions for nursing staff to monitor R3's orthostatic blood pressure monthly. In addition, there was no evidence the orthostatic blood pressures had ever been taken. During an interview on 8/6/15, at 11:36 a.m. a registered nurse (RN)-A confirmed R3's care plan indicated that he was to have orthostatic blood pressures measured on the 19th day of each month. RN-A, however, was unable to produce documentation showing staff had been monitoring the resident's orthostatic blood pressures. RN-A explained R3's often refused monitoring of orthostatic blood pressures and RN-A said "Yes, we should have done [R3's] blood pressures and document any refusal in a progress note." R57 was observed on 8/5/15, between 7:23 a.m. and 9:52 a.m. in her room lying on her bed. R57	21535	these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs Facility policy regarding Use of Psychopharmocologic Medications was reviewed and updated. Facility licensed nursing staff will receive education related to the expectation of following the policy. Licensed nursing staff to review changes to Policy and sign off Provide education for all licensed nursing staff related to use of and monitoring of psychoactive medications R3 and R57 have monthly orthostatic B/P prompted/recorded in TAR Any resident on and antipsychotic has monthly orthostatic B/P¿s per P&P prompted/recorded in TAR Pharmacy consultant will track and report on at Quarterly Quality Council Meeting Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/15/15	

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21535	Continued From page 19 was also observed later in day at 2:29 p.m. sitting in the common area, then as she ambulated with a walker to the elevator assisted by a staff member. R57's electronic medical record (EMR) indicated that R57 was taking medications commonly known to contribute to orthostatic hypertension and/or falls, which included Seroquel (an antipsychotic medication) 25 mg once a day. The medication was started on 12/24/09 at 25 mg, was decreased on 4/16/15 to 12.5 mg once a day and then increased back to 25 mg once a day on 7/30/15. R57 was also prescribed Sertraline (an antidepressant used to manage depression) 150 mg every morning. R57's care plan dated 12/24/15, identified "potential for alteration in mood and psycho-social well being" problem, and directed staff to monitor "lying/sitting blood pressure (BP) every day times three days then monthly when antidepressant or antipsychotic medication initiated or dose increased". R57's progress notes and event reports related to falls revealed that R57 experienced nine falls in the previous six months on 7/6/15, 6/6/15, 5/5/15, 4/20/15, 3/25/15, 3/16/15, 3/13/15, 3/11/15 without injuries and 7/5/15 with a skin tear injury to left elbow which measured 1 centimeter in length. R57's EMR lacked any evidence to indicate that orthostatic BP was being monitored by the nursing staff as directed. Document review of R57's blood pressures results from 5/5/15 to 7/27/15 lacked any supporting documentation that staff had been performing any orthostatic blood pressures as required.	21535		

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21535	Continued From page 20 During an interview on 8/5/15, at 1:44 p.m. RN-B verified no orthostatic blood pressures had been monitored for R57. RN-B also confirmed that R57's care plan directed staff to monitor orthostatic BP every month. RN-B stated that her expectations were that nursing staff would complete orthostatic BP's every month as directed, but "I don't have documentation". RN-B also confirmed that R57 had frequent falls averaging one fall a month. During an interview on 8/6/15, at 10:14 a.m. the director of nursing (DON) stated that they had added orthostatic BP monitoring to "anyone on psychotropic medications". The DON stated that her expectation was that nursing staff would follow resident care plans and that orthostatic BP should be monitored. The DON further stated, "If it's ordered and care planned, I expect my nurses to do it". A 3/20/08 Psychopharmacological Drug Therapy policy directed staff to "Do lying/standing blood pressure every day times three days then monthly for drug initiation and dose increases on residents who are receiving Antipsychotic, Antianxiety, and Antidepressant medication". SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21535		

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21535	Continued From page 21 (21) days.	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled accurately for 2 of 25 medications observed for 2 of 6 residents (R33, R30) during medication administration. Findings include: R33 was prescribed Centrum (multivitamin) 15 milliliters (ml) to be administered by mouth via a gastrostomy tube (feeding tube). During an observation on 8/5/15, at 7:05 a.m. a licensed practical nurse (LPN)-F administered the Centrum via the feeding tube. Following the observation, LPN-F verified R33 did not receive any medications by mouth. LPN-F also verified the label instructed staff to administer the medication "by mouth." LPN-F then placed a Change of Directions sticker on the medication in order to alert staff, and said she would be the label corrected. R30 was prescribed Lantus insulin 12 units every morning. In an observation on 8/5/15, at 8:30 a.m. LPN-D drew up 17 units and explained she believed a medication order change had occurred the night before. LPN-D Verified that the medication should have been labeled with a sticker indicating the order change. LPN-D	21620	Facility has system to employ or a licensed pharmacist consultant. Drugs and biologicals used in the facility must be labeled in accordance ensure the drug regimen of each residents is reviewed at least once a month by a licensed pharmacist. The pharmacist reports any irregularities to the attending physical, and the director of nursing, and these reports must be acted upon. Facility policy on labeling medications and biologicals was reviewed and found to be appropriate. Licensed nursing staff were educated on this policy and procedure. Review of R33 and R 30 Care plan was reviewed and appropriate Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 9/15/15	9/15/15

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21620	Continued From page 22 proceeded to label the medication with the order change sticker. In an interview with the director of nursing on 8/5/15, at 12:05 p.m. it was explained nursing staff had "change order stickers" available on the medication carts, and should have been using them to indicate changes until updated labeled medication was obtained. When interviewed on 8/7/15, at 1:21 p.m., the facility's consultant pharmacist (CP)-A explained the facility should have utilized a direction change sticker should the route have been changed, for example, from oral to gastrostomy tube. She stated that the medication label should have matched the route given. Furthermore, the pharmacist stated that when there is a change in a medication order, the facility needed to send a fax to the pharmacy indicating the order change. The 4/19/10 Medication Labels policy read, "All medications needed to be labeled properly to ensure proper administration of medications. Each prescription medication label should include: resident's name; specific directions for use, including route of administration; strength of medication; prescription number; the name of prescribing practitioner; directions for use; name of pharmacy filling the drug order; date medication is dispensed. Further, the policy stated that if the physician's directions for use change or the pharmacy types an error on the label and it is impractical to return the medication to the pharmacy for re-labeling, the nurse places a signal label on the container indicating that there is a change in directions for use. The provider pharmacy is informed prior to the next refill so the new container will show a corrected label."	21620		

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21620	Continued From page 23 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper labeling of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a dignified dining experience for 8 of 14 residents (R59, R16, R102, R19, R84, R120, R92, R34) observed in three dining rooms on the second and fifth floors. Findings include: R59 was observed on 8/3/15, at 5:05 p.m. as she pulled her food tray towards her body causing the tray with food to tip and liquids being spilled on her lap. One nursing assistant (NA)-H was	21805	Facility has system to ensure policies and procedures to promote care for residents in a manner and environment that maintains or enhances each resident¿s dignity and respect in full recognition of his or her individuality. Facility policy regarding Dignity was reviewed and found to be appropriate. Facility nursing staff will receive education related to the expectation of maintaining or enhancing resident¿s dignity and respect	9/15/15

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21805	Continued From page 24 present in the dining area, who was assisting another resident at the time. Although NA-H did not observed R59 spilling the liquids, NA-H assisted her in putting the tray on table. NA-H moved back and forth between two tables, assisting two different residents who were dependent in eating at the two different tables. At 5:20 p.m. R59 once again pulled her food tray toward her body. NA-H was able to immediately intervene to prevent spilling from re-occurring. During the mean, NA-H generally stood next to R59 as she assisted the resident to eat. At 5:27 p.m. NA-H moved a resident who was in the process of eating her meal to another table. NA-H then moved R59 to the table where the other resident was seated who was being assisted to eat. During dining observations were conducted on the fifth floor on 8/3/15, starting at 5:24 p.m. and the following morning at breakfast, the following was observed: R16 at dinner on 9/3/15, at 5:24 p.m. was seated at a round table holding attempting to scoop food using an adaptive fork, however, the she repeatedly lifted an empty fork to her mouth. She also attempted to stab macaroni, but the noodle fell off the fork before it reached her mouth. R16 picked up the noodle from her lap and put it in her mouth, and then licked her fingers. No staff were present. At 5:34 p.m. NA-A stood next to R16 and asked, "How's it going?" as she handed her a straw. R16 tried to use the straw, but it continually slipped away and no assistance was provided to the resident to drink. NA-A then stood between R16 and another resident, and gave R16 two bites of pasta. The following day breakfast was observed in the	21805	with the Dining Process. Facility policy was developed for Dignified Dining Experience. Nursing staff will be educated on new policy. Care plans were reviewed for R68, R34, R92, R119, R120, R84, R16, R19, R112, R110 (5th Floor) and were accurate or updated. Residents are assisted with meals from a seated position and staff do not leave the area once the meal is placed in front of a resident unless there is an emergency. Care plans were reviewed for R59, R87, R46, R69, R93, R40, R80, R89 (2nd Floor) Residents are assisted with meals from a seated position and staff do not leave the area once the meal is placed in front of a resident unless there is an emergency. ST and OT order for eval and treatment was obtained for R16 to evaluate the amount of assistance that is needed for dining as well as if her adaptive equipment is still appropriate ST and OT order for evaluation and treatment was obtained for R59 to evaluate the amount of assistance that is needed for dining as well as if she needs covered cups at meal times to assist with preventing spills. Director of Nursing or their designee are responsible for monitoring of this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00955	A. BUILDING: _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 25 fifth floor short west dining room at 9:05 a.m. Six residents (R92, R119, R102, R84, R112, and R110) were in the dining room. One resident was feeding herself and another slept. No staff were present in the room. R92 was brought a tray by NA-F, who sat beside the resident to offer assistance. At 9:51 a.m. R16 was seated in the dining area with her head hanging down, eyes closed with her adaptive fork sticking straight up in her hand. Food on a tray was in front of her on the table and no staff were present. A couple minutes later NA-C walked by in the hall glanced in the dining area where the residents were seated with their breakfast trays, and then kept on walking by. NA-G then walking by peered in the dining area then kept on walking by. No other staff were in the dining area. Five minutes later LPN-E pulled up a chair next to R16 and spoke to the resident. R16 lifted her head and opened her eyes, and attempted to drink a meal supplement drink from the straw handed to her by LPN-E, but the straw kept slipping away from R16. LPN-E stated to R16, "Oh my goodness you have had nothing to drink yet. You usually are drinking." R16 LPN-E then assisted the resident to eat a bite of her waffle and stated, "Oh these bites are so big--I don't know how you can eat." R16 had not eaten any of her bacon. LPN-E asked the resident if she was going to eat her bacon, handed her the supplement to drink, and then left the dining room with no other staff present. At 10:16 a.m. R16 was again sitting with her head down and eyes closed with her tray in front of her when NA-F came into the dining room and washed off the table in front of the resident. NA-F then sat down and assisted R16 to take a sip of water and to drink the supplement. Minutes later NA-F removed R16's tray of food and left her with the	21805	Completion Date: 9/15/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00955	A. BUILDING: _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 26	21805		

supplement. NA-F then told NA-C, "Normally we have to leave a staff in the dining room because of the risk of resident choking."

R16's care plan dated 6/22/15, indicated inadequate intake as evidenced by extremely low body mass index related to poor intake and difficulty self-feeding. The resident was to use adaptive equipment, and receive set up, and assistance and encouragement at all meals.

R102 was brought to the dining room at 5:31 p.m. sat briefly, and then got up and walked out of the dining room. Staff returned R102 to the dining room and pulled up a small table in front of the resident and placed a tray of food on the table. NA-A redirected R102 back to eat. NA-A was the only staff in the dining room at that time with the residents. NA-A then redirected R102 back into the dining room and handed R102 her fork to eat. At 5:44 p.m. R102 stood up left the room and NA-A left the dining room to redirect R102 back to her chair to finish her meal.

R102's care plan dated 2/2/15, indicated self-feeding difficulty related to dementia and short attention span with the need for constant cues and reminders at meals, set up, encouragement, a calm and quiet atmosphere at mealtime, reminders to swallow, and to refocus attention on feeding self. In addition, R102 had a restorative level III feeding program dated 4/9/13, that directed staff to provide verbal cues and touch cheek to remind resident to swallow and not pocket food (leave food in mouth un-swallowed) and to decrease distractions.

R19 was served her dinner on 8/3/15, however, she just stared at her food and did not attempt to eat. No staff were in the dining room to offer her

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	00955	A. BUILDING: _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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21805	Continued From page 27	21805		

assistance. At 5:34 NA-A asked R19 if she was going to eat and she shook her head up and down affirmatively. NA-A stood between R19 and another resident as she asked if she had tried her potato, but did not offer assistance to take a bite. Her juice was put within her reach and she was told it was there by NA-A. R19 took one sip and was encouraged to eat her untouched sandwich. At 5:55 p.m. NA-A offered R19 her spoon to eat her potatoes. then left to go straighten up the area by the food carts.

The following morning when R19 was brought into the dining area and given her breakfast tray, she hurriedly gulped down an entire glass of orange juice. LPN-E approached R19 and asked, "Are you hungry today?" as R19 kept scooping up her waffles into her mouth. LPN-E gave R19 her medications and a glass of juice which she again drank in one drink. NA-F stood over R19 as she peeled and an orange and cued the resident to eat. She stirred the resident's cereal and told her, "You still have your cereal here." NA-F then walked away and began clearing trays and straightening up the food carts. NA-F then walked by and gave R19 a bite of cereal, and then sat to assist the resident to finish her cereal while saying, "You are pretty hungry this morning." R19 shook her head up and down in the affirmative to which NA-F responded, "You must have slept through supper last night."

R19's care plan dated 5/5/15, indicated R19's need for both therapeutic and altered texture diet related to having no teeth and dementia. The resident utilized a scoop plate and required assistance and encouragement for all meals.

R84 was seated at a table with food and was not eating during on 8/3/15, at 5:44 p.m. NA-A was in

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	00955	A. BUILDING: _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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21805	Continued From page 28	21805		

the room when R84 stood up. NA-A asked her if she was finished eating or did she want more to eat. R84 said she did want more to eat, but then just stood by the table, and then left the food on her tray and the dining room.

R84's care plan dated 7/8/15, indicated inadequate and variable intake related to dementia, a lack of focus at mealtime and increased calorie usage with movement as evidenced by intakes less than 50%. The goal was for R84 to continue to feed self 50% of meals with cues and encouragement.

R120 was seated at a table with food and was also not eating on 8/3/15, at 5:44. R120 covered up the uneaten food on her tray with a towel, and left the room. NA-A was the only staff in the room and R120 was not redirected the resident back to the table to eat.

R120's care plan dated 4/30/15, indicated R120 fed self after set up and required encouragement to eat at each meal.

After the observations at 5:55 p.m. NA-A proceeded to the alcove where the carts were stored and proceeded to straighten up trays. NA-A walked back and forth from the dining room to the carts, placing trays on the carts. A licensed practical nurse (LPN)-C then entered the dining room and explained, "Today we have five dining areas because of 'behaviors.' Usually we have four dining areas." LPN-C said three NAs and the LPN assigned to work on the unit that evening.

R92 was handed a glass of milk by NA-C who was standing next to the resident at 6:00 when the surveyor entered the fifth floor north dining room. NA-C then stepped away to redirect

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	00955	A. BUILDING: _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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21805	Continued From page 29	21805		

another resident, and then returned and stood next to R92 to assist her to eat. NA-C left R92 again to redirect another resident in the room. NA-C then returned to R92 and sat beside R92 to assist the resident to finish her meal.

R92's care plan dated 5/12/15, indicated set up, encourage food and fluids and assist the resident as she allowed.

R34 was unsupervised for five minutes in the dining room at approximately 10:00 a.m. when she wheeled to the edge of the dining room and stated, "I will be right back." NA-F returned to the dining room and moved R34 into a corner in the dining room as she said to R34, "Let's get you out of the way here." NA-F then placed a tray of food in front of R34.

R34's care plan dated 6/17/15, indicated she had a low body mass index, variable oral intake related to dementia and at times refused assistance and meals. Staff was directed to provide observation, encouragement, and to monitor her self-feeding ability and meals and low BMI, meals on unit with observation and encouragement and monitor self feeding ability and follow per nutrition risk.

On 8/5/15, at 1:03 p.m. and on 8/6/15, at 8:30 a.m. the director of nursing was interviewed regarding the dining room situation. She explained she expected staff to sit down with a resident when assisting with meals. Staff also should have assisted no more than two residents at one time without interruption, unless there was an emergency. The DON stated that it would have presented a safety issue if residents were left with food and staff were not present, and she would have expected staff to be available to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00955	A. BUILDING: _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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21805	Continued From page 30 supervise residents. The facility's 8/22/13, Dignity and Respect of Each Resident Policy read, "Dignity is defined as the maintenance of a resident's self-esteem and self-worth. Saint Anne of Winona expects each employee to treat each and every resident with dignity and respect to maintain self-esteem and self-worth for all residents." SUGGESTED METHOD OF CORRECTION: The director of dietary or designee, could review/revise policies and procedures related to the provision of dignified care and services. Employees could be re-educated on these policies. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **08/03/15** To F2: **08/06/15**	Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: **SAINT ANNE EXTENDED HEALTHCARE**	Provider Number: **245233**	Fiscal Year ending:
Address: **1347 WEST BROADWAY, WINONA, WINONA, MN 55987**		
Telephone Number: F6 **507-454-3621**	State/County Code: **MN / WINONA**	State/Region Code: **MN / 05**
A. F9 **03 - SNF/NF - Medicare/Medicaid** B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11		
Ownership: F12 **05 - Non Profit - Nonprofit Corporation**		
Owned or leased by Multi-Facility Organization: F13 **Yes** Name of Multi-Facility Organization: F14 **Benedictine Health System**		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0**	Alzheimer's Disease F16 **19** Disabled Child Young Adult F18 **0**	

Head Trama F19 **0**	Hospice F20 **0**
Huntington's Disease F21 **0**	Ventilator/Respiratory Care F22 **0**
Other Spec Rehab. F23 **0**	

Does the facility currently have an organized resident group? F24	**Yes**
Does the facility currently have an organized group of family members of residents? F25	**Yes**
Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28	Hours waived per week: F29
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30	Hours waived per week: F31

Does the facility currently have an approved nurse aide training and competency program? F32	**Yes**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

		A	B	C	D
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		**557**	**188**	**0**
Physician Services	F34	**Yes** **No** **No**			
Medical Director	F35		**0**	**0**	**0**
Other Physician	F36		**0**	**0**	**0**
Physician Extender	F37	**No** **No** **No**	**0**	**0**	**0**

Nursing Services	F38	No No No			
RN Director of Nursing	F39		80	0	0
Nurses with Admin Duties	F40		685	0	0
Registered Nurses	F41		124	211	0
Licensed Practical/ Vocational Nurses	F42		362	625	0
Certified Nurse Aides	F43		1475	1906	0
Nurse Aides in Training	F44		0	0	0
Medication	F45		79	4	0
Pharmacists	F46	No No No	0	0	0
Dietary Services	F47	Yes Yes No			
Dietitian	F48		0	44	0
Food Service Workers	F49		793	394	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes Yes Yes	78	7	0
Occupational Therapy Assistant	F52		0	123	0
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes Yes Yes	162	0	0
Physical Therapy Assist	F55		0	96	0
Physical Therapy Aides	F56		70	0	0
Speech/Language	F57	Yes Yes Yes	0	82	0
Therapeutic Recreation Spec.	F58	Yes Yes Yes	0	0	0
Qualified Activities Prof.	F59	Yes Yes Yes	176	0	0
Other Activities Staff	F60	Yes Yes Yes	174	0	0
Qualified Social Workers	F61	Yes No No	121	0	0

Other Social Services Staff	F62	Yes No No	0	13	0
Dentists	F63	No No No	0	0	0
Podiatrists	F64	No No No	0	0	0
Mental Health Services	F65	No No No	0	0	0
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	No No No			
Diagnostic X-ray Services	F68	No No No			
Administration Storage of Blood	F69	No No No			
Housekeeping Services	F70	Yes No No	937	119	0
Other	F71		57	0	0
Name of Person Completing Form: **Dana Marquardt/Carol Ehlinger**					Date: **08/07/15**

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I'm finished and would like to exit the application.	Exit

SAINT ANNE EXTENDED HEALTHCARE				
Provider No. **245233**	Medicare F75 **12**	Medicaid F76 **44**	Other F77 **43**	Total Residents F78 **99**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **0**	F80 **73**	F81 **26**
Dressing	F82 **0**	F83 **93**	F84 **6**
Transferring	F85 **9**	F86 **80**	F87 **10**
Toilet Use	F88 **7**	F89 **87**	F90 **5**
Eating	F91 **43**	F92 **50**	F93 **6**

A. Bowel/Bladder Status	**B. Mobility**
F94 **4** With indwelling or external catheter.	F100 **1** Bedfast all or most of time..
F95 Of total number of residents with catheters, **3** were present on admission.	F101 **89** In chair all or most of time.
	F102 **6** Independently ambulatory.

F96 **88** Occasionally or frequently incontinent of bladder.

F97 **47** Occasionally or frequently incontinent of bowel.

F98 **0** On individually written bladder training program.

F99 **0** On individually written bowel training program.

F103 **68** Ambulation with assistance or assistive device.

F104 **0** Physically restrained.

F105 Of total number of residents with restrained, **0** were admitted with orders for restraints.

F106 **17** With contractures.

F107 Of total number of residents with contractures, **16** had contractures on admission.

C. Mental Status

F108 **0** With mental retardation.

F109 **68** With documentation signs and symptoms of depression.

F110 **21** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **56** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **30** With behavioral symptoms.

F113 **3** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **0** Receiving health rehabilitative services for MI/MR.

D. Skin Integrity

F115 **7** With pressure sores (exclude stage I).

F116 **2** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **71** Receiving preventive skin care.

F118 **1** With rashes.

E. Special Care

F119 **5** Receiving hospice care benefit.

F120 **0** Receiving radiation therapy.

F121 **0** Receiving chemotherapy.

F127 **0** Receiving suction.

F128 **11** Receiving injections (exclude vitamin B12 injections)

F129 **2** Receiving tube feedings.

F122 **2** Receiving dialysis.	F130 **34** Receiving mechanically altered diets including pureed and all chopped food (not only meat).
F123 **2** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.	F131 **17** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).
F124 **17** Receiving respiratory treatment.	F132 **19** Assistive devices while eating.
F125 **0** Receiving tracheostomy care.	
F126 **4** Receiving ostomy care.	

F. Medication	**G. Other**
F133 **61** Receiving any psychoactive medication.	F140 **10** With unplanned significant weight loss/gain.
F134 **20** Receiving antipsychotic medications.	F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **15** Receiving antianxiety medications.	F142 **1** Who use non-oral communicationdevices.
F136 **57** Receiving antidepressant medications.	F143 **99** With advance directives.
F137 **1** Receiving hypnotic medication.	F144 **86** Received influenza immunization.
F138 **6** Receiving antibiotics.	F145 **91** Received pneumococcal vaccine.
F139 **70** On pain management program.	

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Stephanie Pichner	**RN, Director of Nursing**	**08/07/2015**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **No**
F148 Medication error rate **0%**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245233	SAINT ANNE EXTENDED HEALTHCARE

Type of Survey (select all that apply):

I	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 30923	08-03-2015	08-06-2015	0.25	1.00	26.50	2.00	6.00	4.00
2. 32976	08-03-2015	08-05-2015	0.00	1.00	16.50	2.50	6.00	0.00
3. 33937	08-04-2015	08-06-2015	0.00	1.00	20.00	0.00	6.00	8.00
4. 34086	08-03-2015	08-06-2015	0.50	1.00	23.00	2.00	6.00	6.50
5. 35574	08-03-2015	08-06-2015	0.00	1.00	23.00	2.00	6.00	7.00
6. 35990	08-03-2015	08-06-2015	0.00	1.00	23.00	2.00	8.00	10.65
7.								
8.								
9.								
10.								

Total Supervisory Review Hours	14.00
Total Clerical/Data Entry Hours.....	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	Y

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245233	SAINT ANNE EXTENDED HEALTHCARE

Type of Survey (select all that apply):

H	K	I			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 25822	08-18-2015	08-18-2015	0.50	0.00	3.75	0.00	2.00	1.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.75

Total Clerical/Data Entry Hours..... 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245233	**SAINT ANNE EXTENDED HEALTHCARE**	*K4 **08/18/2015**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5233023

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER: K1 245233
1. (B) MEDICAID I.D. NO.: K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY
SAINT ANNE EXTENDED HEALTHCARE

2. (A) MULTIPLE CONSTRUCTION (BLDGS) K3
A. BUILDING X
B. WING
C. FLOOR

2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)
1347 WEST BROADWAY
WINONA, MN 55987

A. (●) Fully Sprinklered (All required areas are sprinklered)
B. ( ) Partially Sprinklered (Not all required areas are sprinklered)
C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR
[✔] MEDICARE [✔] MEDICAID

4. DATE OF SURVEY K4: 08/18/2015

DATE OF PLAN APPROVAL K6:

SURVEY UNDER K7
5. [✔] 2000 EXISTING 6. [ ] 2000 NEW

5. SURVEY FOR CERTIFICATION OF
1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW
1. (●) ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY)_____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (●) NO

6. BED COMPOSITION

a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID
109	0	109	109	0

7. A. (●) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)
1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. (●) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) OFSES 5. ( ) PERFORMANCE BASED DESIGN
B. ( ) THE FACILITY DOES NOT MEET THE STANDARD K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
Gary Schroeder	Deputy State Fire Marshal	State Fire Marshal	08/18/2015
SURVEYOR ID K10: 25822			
FIRE AUTHORITY OFFICIAL *(Signature)*	TITLE	OFFICE	DATE
	Interim Fire Safety Supervisor	State Fire Marshal	8/18/2015

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES **BUILDING CONSTRUCTION**				K11 - Nursing Home is separated by 2 hour rated fire wall from Assisted Living
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2	◉	○	○	K11 - observation revealed, that the 2 hour fire rated building separation wall between the nursing home and assisted living has a open penetration around the fire alarm cable above the lay in ceiling.
K12	2000 EXISTING Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	◉	○	○	
	1 ◉ I (443), I (332), II (222) — Any Height				K12 -
	2 ○ II (111) — One story only (non-sprinklered).				
	3 ○ II (111) — Not over three stories with complete automatic sprinkler system.				1962 - Original 6 story - With no basement
	4 ○ III (211) — Not over two stories with complete automatic sprinkler system.				
	5 ○ V (111) — Not over two stories with complete automatic sprinkler system.				
	6 ○ IV (2HH) — Not over two stories with complete automatic sprinkler system.				
	7 ○ II (000) — Not over two stories with complete automatic sprinkler system.				
	8 ○ III (200) — Not over one story with complete automatic sprinkler system.				
	9 ○ V (000) — Not over one story with complete automatic sprinkler system.				
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*				

ID PREFIX					MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.							
	1		I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2		II (111)	Not over three stories with complete automatic sprinkler system				
	3		III (211)	Not over one story with complete automatic sprinkler system.				
	4		V (111)					
	5		IV (2HH)					
	6		II (000)					
	7		III (200)	Not Permitted				
	8		V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*							
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)				◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s* B	◉	○		
	2000 NEW Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s*_____				
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s* B	◉	○		
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. *Indicate flame spread rating/s*_____				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	2000 EXISTING Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3 In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.	○	○	◉	
	CORRIDOR WALLS AND DOORS				
K17	2000 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 *If the walls have a fire resistance rating, give rating* smk rest *if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.*	◉	○		
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3	◉	○		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.^{2} and the opening is installed in bottom half of the wall (80 in.^{2} in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	○	◉	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: ☑ (a) The required manual fire alarm system and ☐ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☑ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.	◉	○	○	K21 - Magnetic Door hold opens, that have full corridor smoke detection, that is interconnected with the building fire alarm system.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Describe method used in REMARKS				
	SMOKE COMPARTMENTATION AND CONTROL				
K23	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2	◉	○	○	
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2				
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1	◉	○	○	
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.				
K25	2000 EXISTING Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	◉	○	○	
	2000 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5				
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	◉	○	○	
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7	◉	○	○	
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: Provider Type / Swinging Doors / Horizontal Sliding Doors Hospitals and Nursing Facilities: 41.5 inches (105 cm) / 83 inches (211 cm) Psychiatric Hospitals and Limited Care Facilities: 32 inches (81 cm) / 64 inches (163 cm) 18.3.7.7				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5	◉	○	○	K29 - observation revealed, that the following was found: 1. Basement - Laundry room #12 (over 100 sq ft) the entrance door will not shut and latch 2. Basement - Laundry Folding room (over 50 sq ft) a. No automatic door closer b. Door being propped open c. Open penetration below drop in ceiling around sprinkler line
	Describe any mechanical smoke control system in REMARKS.				
	HAZARDOUS AREAS				
K29	2000 EXISTING One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	○	◉	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	✔	✔	
c. Laundries (greater than 100 sq feet)	✔	✔	
d. Repair Shops and Paint Shops	✔	✔	
e. Laboratories (if classified a Severe Hazard - see K31)			✔
f. Combustible Storage Rooms/Spaces (over 50 sq feet)	✔	✔	
g. Trash Collection Rooms	✔	✔	
i. Soiled Linen Rooms	✔	✔	

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			
c. Laundries (greater than 100 sq feet)			
d. Repair, Maintenance and Paint Shops			
e. Laboratories (if classified a Severe Hazard - see K31)			
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)			
g. Trash Collection Rooms			
i. Soiled Linen Rooms			
m. Combustible Storage Rooms/Spaces (over 100 sq feet)			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles	☑	☐	☑

ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ☑ The corridor is at least 6 feet wide ☑ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ☑ The dispensers shall have a minimum spacing of 4 ft from each other ☑ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ☑ Dispensers are not installed over or adjacent to an ignition source. ☑ If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623	◉	○	○	
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating “No Exit”. 7.10, 18.2.10.1, 19.2.10.1	◉	○	○	
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2	◉	○		
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	◉	○	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Exit enclosures (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2, 8.2.5.4, 18.3.1.1, 18.2.2.3				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K34	Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	◉	○	○	
K35	The capacity of required mean of egress is based on its width, in accordance with 7.3.	◉	○		
K36	Travel distance (exit access) to exits are measured in accordance with 7.6. • Room door to exit ≤ 100 ft (≤ 150 ft sprinklered) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • Point in room to room door ≤ 50 ft • Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	◉	○		
K37	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10	◉	○	○	
	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	◉	○		
K39	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5	◉	○		
	2000 NEW Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 *If doors lead directly to grade from each room, check this box.* ☐	◉	○		
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2	◉	○		
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key. Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5	◉	○	○	
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2	◉	○	○	
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5	◉	○	○	
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1	◉	○		
	ILLUMINATION				
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8	◉	○		
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.	◉	○		
K105	2000 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			☑	
	EMERGENCY PLAN AND FIRE DRILLS				
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1	◉	○	○	
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	◉	○		
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,	◉	○		
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	◉	○	○	
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				K54 - The facility has full corridor smoke detection, with smoke detection in areas open to the corridor, that are interconnected to building fire alarm system, that has automatic notification to the fire department.
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System ☐ Corridors ☐ Rooms ☐ Bath	○	○	◉	
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	◉	○		
	Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8	◉	○		
	2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
K60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1	◉	○		
	AUTOMATIC SPRINKLER SYSTEMS				
K56	2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13	◉	○	○	
	2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
K154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.	◉	○	○	
	A. Date sprinkler system last checked and necessary maintenance provided. 04/13/2015				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. General				K62 - observation revealed the following: 1. Observation revealed that the spare sprinkler head box does not contain 2 spare fire sprinkler heads for each type head in the facility 2. Fire Pump packing is bad and it was also noted on the annual sprinkler report from General Sprinkler on 4/13/15. At the time of this inspection the above have not been corrected.
	C. Note the source of water supply for the automatic sprinkler system. Citv Water				
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)				
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	○	◉	○	
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13	◉	○	○	
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6	○	◉		K64 - observation reveal that in the basement conference room # 30, the fire extinguisher has not been annual inspected since 1/2014
	SMOKING REGULATIONS				
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	○	○	○	
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2	◉	○	○	K67 - The K67 deficiency for corridor is used as a plenum has been correct by the system has been balance by Winona Heating on 09/27/2011. Balance report was furnished by facility
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.	◉	○	○	
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96	◉	○	○	
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8	◉	○	○	
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82 (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.	○	○	◉	
K160	2000 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators & Escalators*. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	◉	○	○	
	2000 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.2.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)	◉	○	○	
	2000 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All escalators and conveyors comply with ASME/ANSI A17.1, *Safety Code for Elevators and Escalators.* 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
K73	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4	◉	○	○	
K74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 ☑ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. ☑ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 ☑ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	◉	○	○	
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft^2 (20.4 L/m^2). A	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5	◉	○	○	
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)	○	○	◉	
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1	○	○	◉	
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)	○	○	◉	
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).	○	○	◉	
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).	○	○	◉	
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).	○	○	◉	
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)	○	○	◉	K76 - observation revealed that the 2nd floor west oxygen storage room found the following: 1. Empty cardboard boxes being stored in room 2. One "E" cylinder not secured 3. Empty and full "E" cylinders intermingled
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	○	◉	○	
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	○	○	◉	
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3	○	○	◉	
K140	Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99)	○	○	◉	
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	◉	
K143	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)	○	○	◉	
	ELECTRICAL AND EMERGENCY POWER				
K106	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)	◉	○	○	
K107	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1	◉	○		
K108	2000 NEW (INDICATE N/A FOR EXISTING) Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2			☑	
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)	◉	○	○	
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)	○	○	◉	
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	◉	○		
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1		* K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

☐

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT 8 SLOW 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE

K5: ☐ e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)

A2. ☐ (ACCEPTABLE POC)

A3. ☐ (WAIVERS)

A4. ☐ (FSES)

A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐ FULLY SPRINKLERED (All required areas are sprinklered)

B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. ☐ NONE (No sprinkler system)

* MANDATORY

SAINT ANNE EXTENDED HEALTHCARE
1347 WEST BROADWAY
WINONA, MN 55987

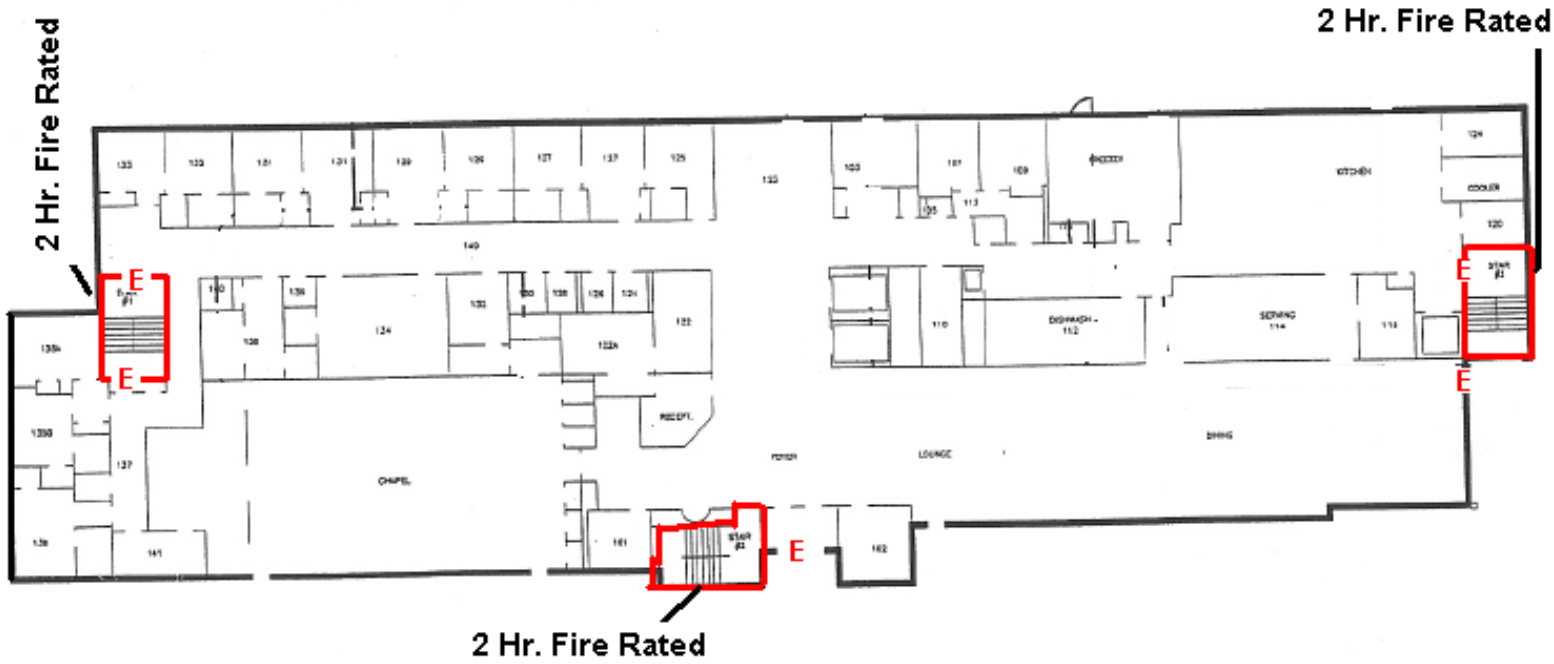
Smoke Barrier
Fire Seperation
Required EXIT E

Fully Sprinkled

N

1st Floor

ORIGINAL
For Fire Marshal Division File
12/06/2011



SAINT ANNE EXTENDED HEALTHCARE
1347 WEST BROADWAY
WINONA, MN 55987

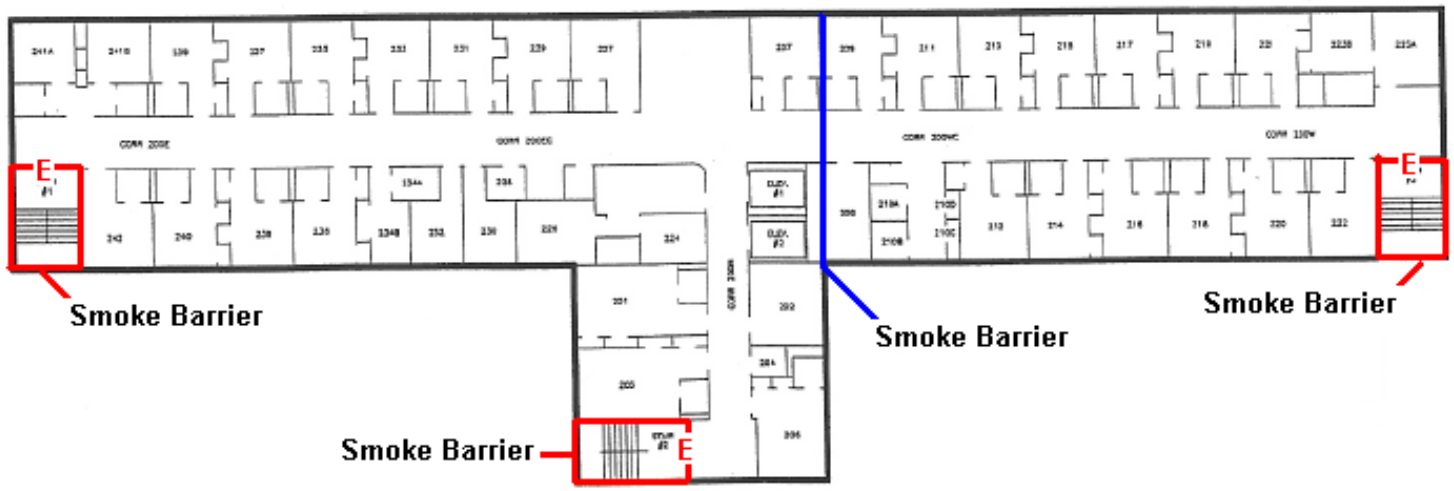
Smoke Barrier
Fire Seperation
Required EXIT E

Fully Sprinkled

N

2nd Floor

ORIGINAL
For Fire Marshal Division File
12/06/2011



SAINT ANNE EXTENDED HEALTHCARE
1347 WEST BROADWAY
WINONA, MN 55987

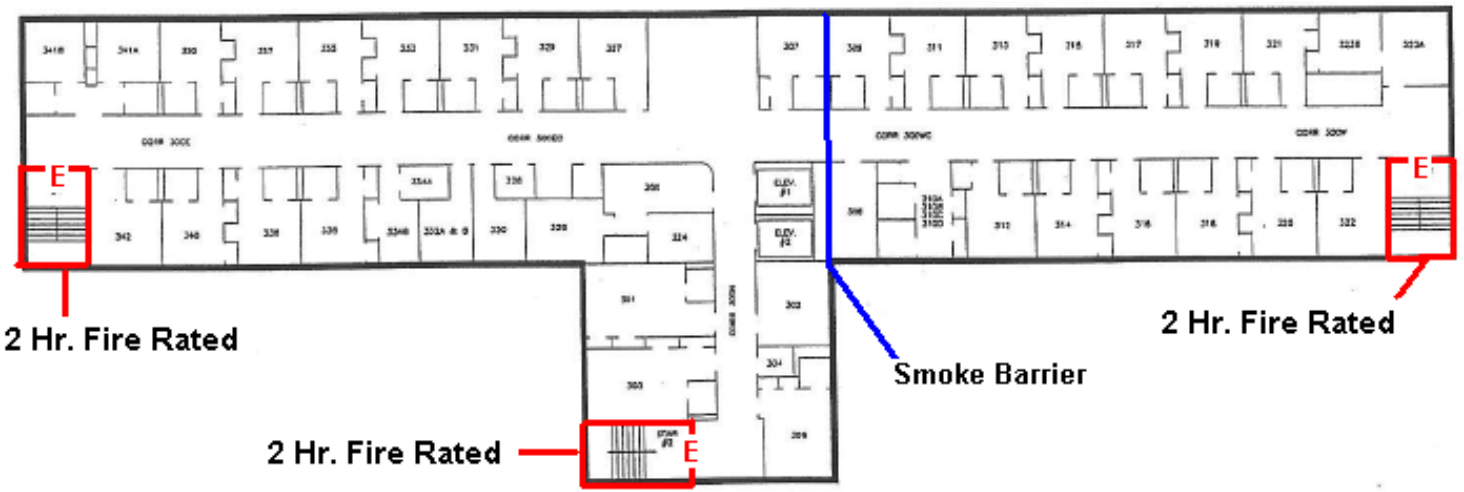
Smoke Barrier
Fire Seperation
Required EXIT E

Fully Sprinkled

N

3rd Floor

ORIGINAL
For Fire Marshal Division File
12/06/2011



SAINT ANNE EXTENDED HEALTHCARE
1347 WEST BROADWAY
WINONA, MN 55987

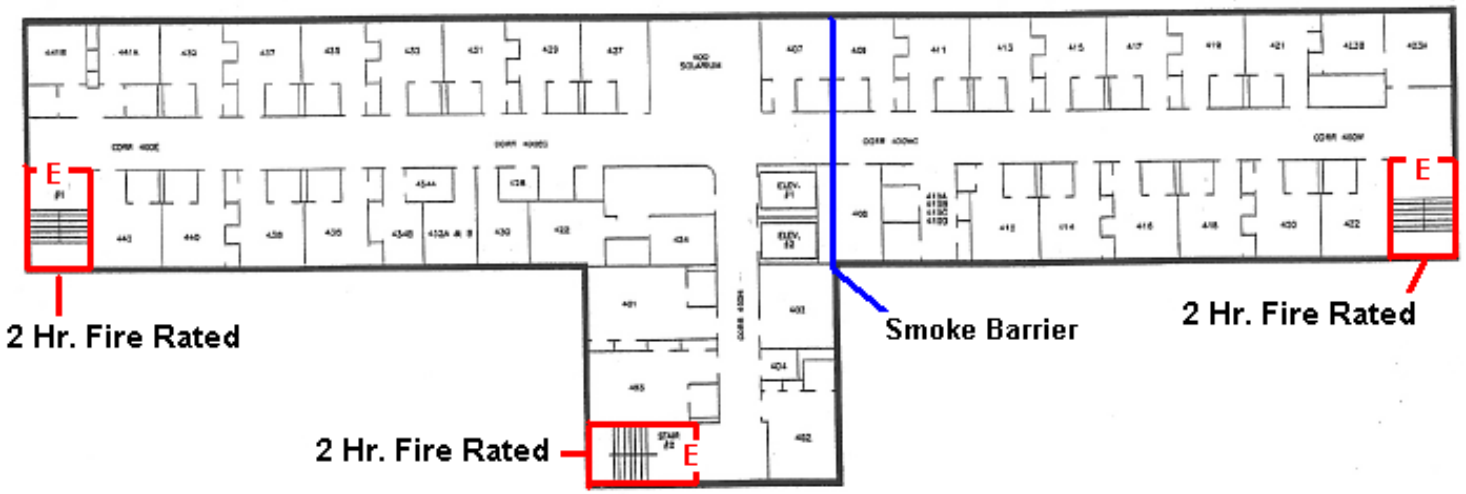
Smoke Barrier
Fire Seperation
Required EXIT E

Fully Sprinkled

N

4th Floor

ORIGINAL
For Fire Marshal Division File
12/06/2011



SAINT ANNE EXTENDED HEALTHCARE
1347 WEST BROADWAY
WINONA, MN 55987

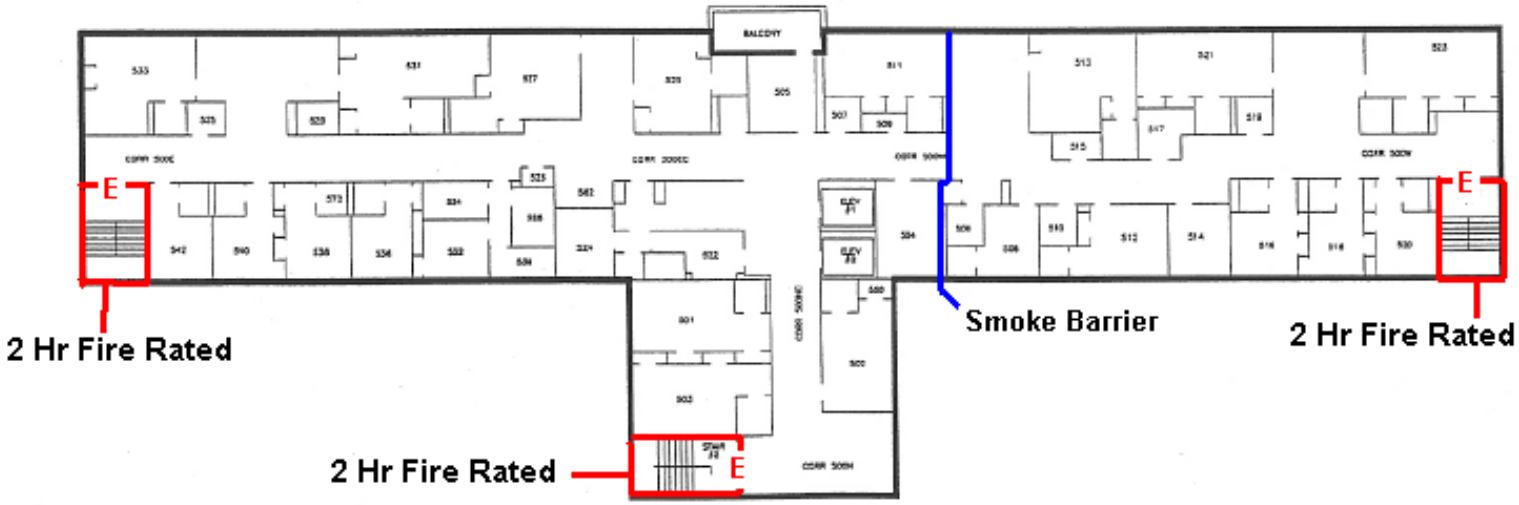
Smoke Barrier
Fire Seperation
Required EXIT E

Fully Sprinkled

N

5th Floor

ORIGINAL
For Fire Marshal Division File
12/06/2011



SAINT ANNE EXTENDED HEALTHCARE
1347 WEST BROADWAY
WINONA, MN 55987

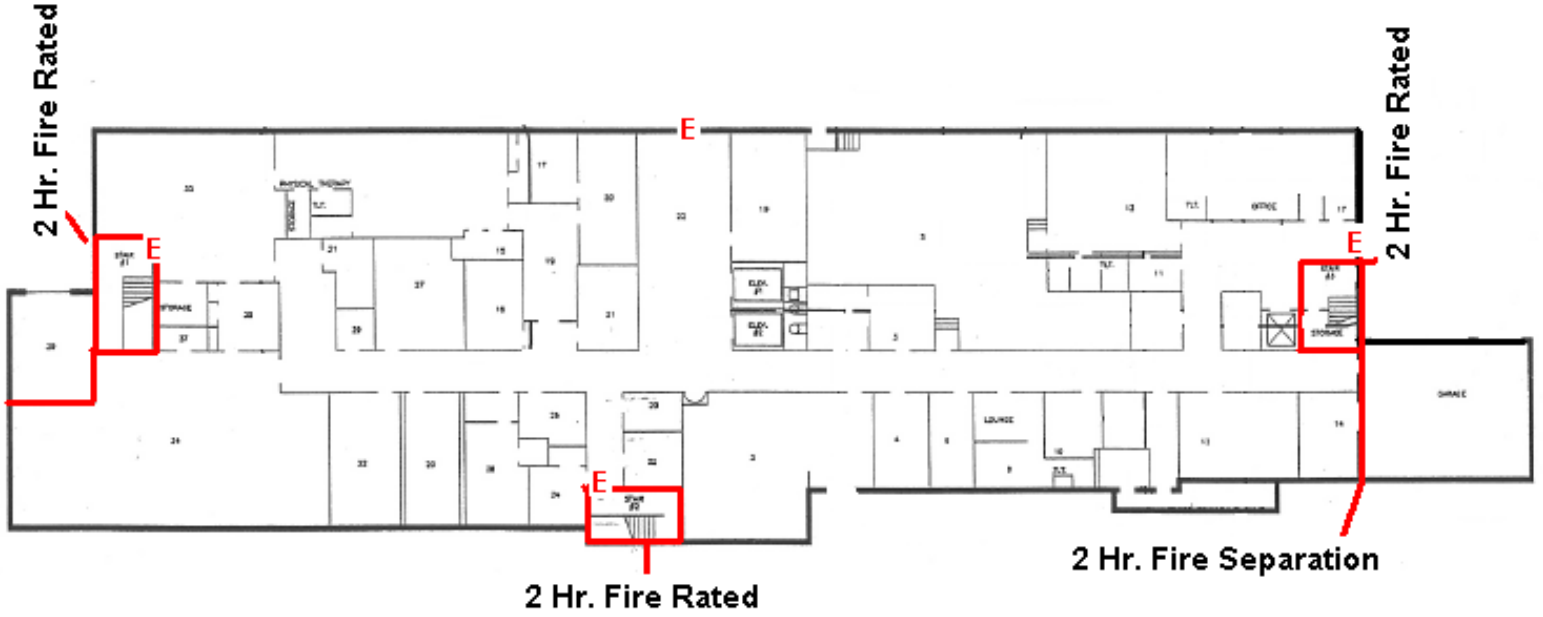
Smoke Barrier
Fire Seperation
Required EXIT E

Fully Sprinkled

N

Ground Floor

Emergency Generator



SAINT ANNE EXTENDED HEALTHCARE
1347 WEST BROADWAY
WINONA, MN 55987

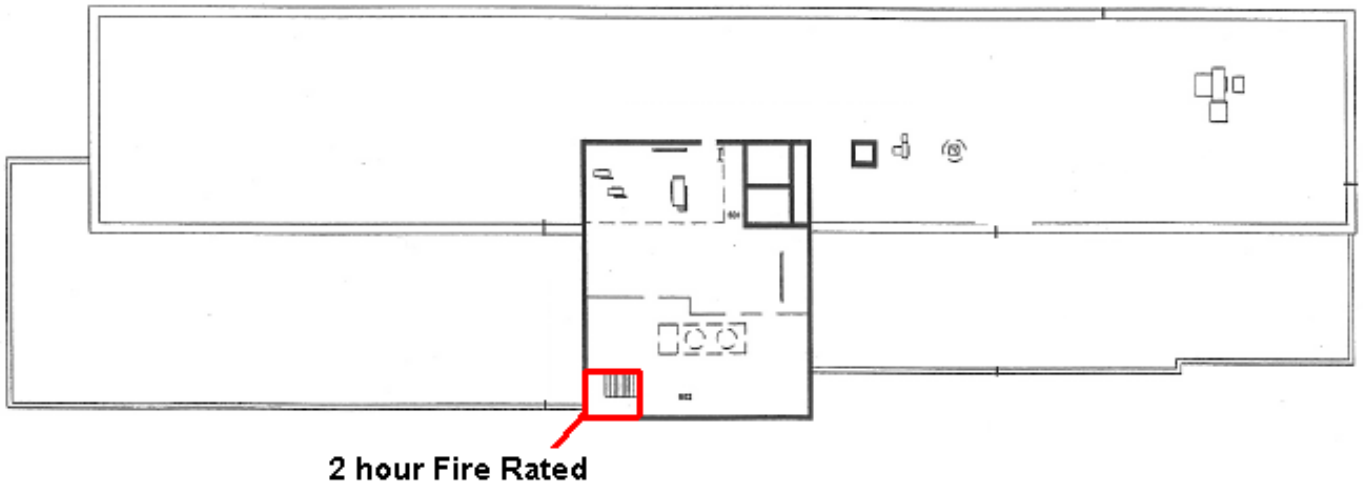
Smoke Barrier
Fire Seperation
Required EXIT E

Fully Sprinkled

N

Penthouse

ORIGINAL
For Fire Marshal Division File
12/06/2011



PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5233023	SAINT ANNE EXTENDED HEALTHCARE	08/18/2015

Administrator: F5233023 Phone Number: 245233

Email address: jodi.barton@bhshealth.org

State Fire Inspector: Gary Schroeder # 76

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

☐ **At the time of this inspection, this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to: ☑ SNF/NF ☐ Hospital ☐ ICFMR ☐ ASC Facilities participating in the Medicare/Medicaid programs.**

☑ **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	☑ **Draft Summary of Deficiency(ies)** ☐ **Revisit** ☐ **Clearance**
K29 S/S=D	1. Basement - Laundry room #12 (over 100 sq ft) entrance door will not shut and latch 2. Basement - Laundry Folding room (over 50 sq ft) a. No automatic door closer b. Door being propped open c. open penetration below drop in ceiling around sprinkler line
K62 S/S=D	1. No 2 each type of each sprinkler head in spare sprinkler head box 2. Fire Pump packing is bad and it was also noted on the annual sprinkler report from General on 4/13/15
K11 S/S=D	1st floor - The 2 hour fire rated wall between NH/Assisted Living had open penetration around fire alarm cabling - Check the entire wall - both sides
K76 S/S=D	2nd floor - west oxygen storage room 1. empty cardboard boxes being stored in room 2. One "E" cylinder not secured 3. Empty and full "E" cylinders intermixed
K64 S/S=D	Basement in room # 30, fire extinguisher has not had an annual inspection since 1/2014

S5233025

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for ADMINISTRATOR: Jodi.Barton@bhshealth.org

National Provider Identifier (NPI) Number: 1134123532

One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: SAINT ANNE EXTENDED HEALTHCARE City: WINONA

Name of Legal Entity Operating Provider: SAINT ANNE OF WINONA

Name and Address of Governing Board President:

Name: GABRIEL MANRIQUE
Address: 241 OAK LEAF DR

City/State/Zip: WINONA, MN 55987

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: Saint Anne Extended Healthcare City: Winona

Name of Legal Entity Operating Provider: Saint Anne of Winona

Name and Address of Governing Board President:

Name: Alberta Rosberg
Address: 102 E. Third St.
Winona, MN 55987

City/State/Zip:

SIGNATURE

Completed by: Jodi Barton
Title: Administrator/CEO
Date: 8/3/15